



**The California Managed Risk Medical Insurance Board**

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**Board Members**

Clifford Allenby, Chair

Areta Crowell, Ph.D.

Richard Figueroa

Sophia Chang, M.D., M.P.H

**Ex Officio Members**

Jack Campana

Kimberly Belshé

Dale E. Bonner

The following vision model contract amendment was updated per the Board's direction to staff at the October 24, 2007, meeting



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## VISION

Date: October \_\_\_\_, 2007

To: Healthy Families Program Participating Health, Dental, and Vision Plans

From: Denise M. Arend  
Chief Deputy Director

Re: Healthy Families Program 2008-09 Contract Amendment Package

This electronic package provides the instructions and documents for completing the 2008-09 amendment to your 2005-08 Healthy Families Program (HFP) contract. **All documents, except your rate submission, are due via email by December 7, 2007 and one hard copy in a three-ring binder mailed by December 11, 2007. Rate development templates are due via email by January 7, 2008, and one signed Actuarial Certification mailed by January 9, 2008.**

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## CONTRACT LANGUAGE CHANGES

The attached e-files of Exhibit A and Exhibit B include the draft changes considered at the Board's September 19, 2007 meeting. We did not receive any suggested revisions to the model contract language from vision plans.

The final language changes are summarized below.

### EXHIBIT A

I. Introduction, section D, Changing Vision Care Providers, paragraph 2

2. *Clarifies when vision care providers are added or deleted from the Contractor's Provider Directory and this activity either opens a new zip code to the coverage contemplated or would materially impair the Contractor's capacity to perform under the Agreement, that a copy of the documentation required in I.C.2 must be provided when it is submitted to the state licensing agency.*

II. Enrollment, section A, Eligibility, paragraph 1

1. *Clarifies that the State will conduct all eligibility determinations and that the Contractor shall not attempt to conduct its own eligibility investigations or inquiries.*

II. Enrollment, section E, Provider Directory and Evidence of Coverage Booklet, paragraph 3.d

- 3.d. *Clarifies the Contractor's requirement to submit two print copies and one electronic copy on compact disk of an updated Evidence of Coverage booklet (or amended pages) as well as one print copy of the updated Provider Directory.*

II. Enrollment, section H, Enrollment Data, paragraph 1

1. *Clarifies that, the State is the official record holder of subscriber information and that the Contractor shall not make any changes to the subscriber information unless the changes are transmitted by the State.*

II. Enrollment, section K, Public Awareness, paragraph 5

5. *Adds the requirement that the Contractor's designated staff must complete the State's online application assistance training before beginning any application assistance activity.*

III. Customer Service, section C, Cultural and Linguistic Services, paragraph 2.a

- 2.a. *Adds a requirement that the language materials are to be translated into the subscribers' preferred written language based on the Contractor's enrollment data as of December 1 of each year only after the State provides this information.*

IV. Covered Services and Benefits, section A, Covered and Excluded Benefits, paragraph 1

1. *Clarifies that, except as required by any provision of applicable law, the benefits described in Program regulations shall be covered benefits under the terms of the Agreement.*

EXHIBIT B

II. Fiscal Control Provisions, section A, Minimum Loss Ratio, paragraph 2

2. *Adds a requirement for an interim loss ratio for July through November of the current year.*

II. Fiscal Control Provisions, section C, Availability of Federal Funds, paragraphs 1, 2, and 3

1. *Clarifies that the agreement is written "based on then-existing regulations and federal executive agencies interpretation and application of relevant statutes but before ascertaining" the availability of Congressional appropriation of funds in order to avoid program and fiscal delay.*
2. *Clarifies that Agreement is subject to any additional restrictions, limitations, or conditions "made applicable at any time by:*
  - a. *enactments of Congress*
  - b. *regulations promulgated or amended by federal or executive agencies, or*
  - c. *the interpretation or application by federal executive agencies of relevant regulations and statutes."*
3. *Clarifies that if sufficient funds are not appropriated or the provisions as described in Exhibit B, Items II.C.2.a, b and c, affect the provisions, terms or funding of the Agreement, that the Agreement shall be amended to reflect these changes.*

Attachment I Plan Coverage Area Instructions – updated for 2008-09 submission

Enclosure 1 Frequently Asked Questions and  
Language Grid Changes – updated for 2008-09 submission

Enclosure 2 Evidence of Coverage Instructions – updated for 2008-09 submission

Enclosure 4 Plan Fact Sheet – updated for 2008-09 submission

Enclosure 5 Cultural and Linguistic Survey – updated for 2008-09 submission

Enclosure 6 Rate Development Template – updated for 2008-09 submission

**EVIDENCE OF COVERAGE, PLAN DESCRIPTION, FREQUENTLY ASKED  
QUESTIONS (FAQ) CHART, AND LANGUAGE GRID CHANGES**

Indicate any changes to your current (2007-08) EOC/COI by submitting **only** the pages with changes indicated on them, **not** your entire EOC/COI. When submitting the changes, include the entire page that will be changed so we can review the change in context. Use ~~striketrough~~ for text you are deleting and underline text you are adding. Additionally, provide a separate document summarizing the changes your plan is proposing, including the page number and an explanation for each change.

A customized plan document package including the Plan Description, Frequently Asked Questions Chart, and Language Grid will be emailed to each plan by October 31, 2007. Instructions for changes to these documents can be found in Enclosure 1 in the 2008-09 Contract Amendment Package.

## **GEOGRAPHIC GRIDS AND ZIP CODE CHANGES**

Please submit Geographic Area Grids and Partial County Coverage Areas for the 2008-09 benefit year electronically via a customized Plan Coverage Area Workbook, entitled "Attachment 1, Plan Coverage.xls." The customized Plan Coverage Area Workbook clearly identifies your current coverage area and allows for the identification of proposed coverage areas in both partial and full counties for the 2008-09 benefit year. A customized Plan Coverage Area Workbook for 2008-09 will be e-mailed to each plan separately and contains instructions on how to complete the workbook.

**Note: MRMIB must receive confirmation that you have obtained regulatory approval for any expansion areas. Confirmation of your regulatory approval from DMHC must be sent via email to [HFPCContract08@mrrib.ca.gov](mailto:HFPCContract08@mrrib.ca.gov) no later than March 14, 2008. If your regulatory approval for expansion areas is not received by MRMIB by March 14, 2008, MRMIB reserves the right, at its sole discretion, to not include the expanded coverage areas in your 2008-09 contract amendment.**

## **DEADLINES**

By **December 7, 2007**, email to [HFPCContract08@mrrib.ca.gov](mailto:HFPCContract08@mrrib.ca.gov) the following documents:

- Plan Coverage Workbook
- Updated Evidence of Coverage/Certificate of Insurance
- Plan Fact Sheet
- Plan Description
- Language Grid
- Frequently Asked Questions Chart

By **December 11, 2007** please submit one paper copy of the Comparative Chart and all requested documents (except the rate development template) filed in a three-ring binder to:

Denise M. Arend, Chief Deputy Director  
Managed Risk Medical Insurance Board  
1000 G Street, Suite 450  
Sacramento, CA 95814

By **January 7, 2008**, email your completed schedules in the Rate Development Template to [HFPRates08@mrmib.ca.gov](mailto:HFPRates08@mrmib.ca.gov).

By **January 9, 2008**, mail a signed Actuarial Certification (Schedule 11 for ALL health plans, Schedule 6 for health plans with AIM babies, and Schedule 10 for dental and vision plans) to:

Jackie Baker, Financial Operations Officer  
Managed Risk Medical Insurance Board  
1000 G Street, Suite 450  
Sacramento, CA 95814

If you have any questions, please call me at (916) 324-4695 or e-mail me at [darend@mrmib.ca.gov](mailto:darend@mrmib.ca.gov).

Enclosures

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## **EXHIBIT A SCOPE OF WORK**

### **I. INTRODUCTION**

#### **A. Act and Regulation**

This Agreement is in accord with and pursuant to Section 12693 et. seq., Part 6.2 of Division 2 of the California Insurance Code, which establishes the Healthy Families Program (hereinafter the Program). The Agreement is also in accord and pursuant to Title XXI of the Social Security Act and its implementing federal regulations, which establish the State Children's Health Insurance Program and provide authorization and federal funding for the Healthy Families Program, and Title 10, Chapter 5.8 of the California Code of Regulations (hereinafter Program Regulations). Terms and conditions used in the Program Regulations shall have the same and identical meanings in this Agreement.

#### **B. Specialized Health Care Service Plan**

This Agreement is entered into by the Contractor and the State for the purpose of providing vision coverage for subscribers determined to be eligible by the State. The method of delivery of the insured vision benefits shall be a specialized health care service plan. The Contractor agrees to provide and maintain the specialized health care service plan.

#### **C. Geographic Areas Covered**

1. The Contractor's participation in the Program is limited to enrollment of Program subscribers who reside in the Contractor's licensed service area accepted by the State. These geographic areas are described in Attachment I: Geographic Area Grid.
2. Geographic coverage in the Program may be changed only upon written approval by the State. The Contractor shall request such approval in writing at least sixty (60) days prior to the date the change will take place and shall include documentation from the state licensing agency that approved the changes to the Contractor's licensed service area.
3. If the change requested is to withdraw from an area due to a plan initiated licensure change or removal, the State shall cease new enrollment of subscribers in the area and the Contractor shall continue to maintain and provide services to subscribers in the area until the end of the benefit year.

4. If the change requested is to withdraw from an area due to a plan initiated licensure change or removal for a date that is not concurrent with the Program's open enrollment, then the Program will hold a special open enrollment pursuant to Exhibit B, Item I.C.

D. Changing Vision Care Providers

1. The Contractor's organization shall consist of the list of vision care providers to be provided to the State. These providers are listed in the Contractor's Provider Directory. The Contractor agrees to provide copies of the Provider Directory to the State upon request, and to annotate, on a quarterly basis, the information required in Item II.I. with a notation that indicates the providers that are accepting new Program subscribers.
2. Vision care providers shall be deemed added to or deleted from the Contractor's Provider Directory as contracts between the Contractor and vision care providers begin or end. If such contract activity either opens a new zip code to the coverage contemplated by this Agreement or would materially impair the Contractor's capacity to perform under this Agreement, the Contractor shall, **at the time of submission to the state licensing agency, provide a copy of the documentation referenced in Section I.C.2, shall** give not less than sixty (60) days written notice to the State and shall implement the change only upon written approval by the State.

E. Term of Agreement

The term of this Agreement shall be from July 1, 2005 through June 30, 2008. At its sole discretion, the State may exercise the option to negotiate an Agreement for two subsequent one-year terms. The State shall exercise this option no later than sixty (60) days prior to the expiration date of this Agreement. Such extension shall be by an amendment to this Agreement. Reimbursement rates applicable to each subsequent one-year term shall be negotiated by the parties and included in the amendment. Renewal of the Agreement is contingent upon successful performance by the Contractor, as determined by the State at its sole discretion.

## II. ENROLLMENT

### A. Eligibility

1. All subscribers who are determined eligible by the State in accordance with the Act and Program regulations are eligible to enroll in a program vision plan. The State certifies that its enrollment process will not be prejudicial to the Contractor or other participating vision plans. The Contractor may observe the State's eligibility determination and enrollment process. **The Contractor agrees that the State conducts all eligibility determinations and shall not attempt to conduct its own eligibility investigations or inquiries.**
2. Upon notification by the State, in writing and electronically when appropriate, the Contractor agrees to serve subscriber parents in the Program. Rates and other contractual terms shall be negotiated between the Contractor and the State prior to implementation and shall be implemented through an amendment to this Agreement.

### B. Conditions of Enrollment

1. The Contractor agrees to enroll all subscribers referred by the State, in writing and electronically when appropriate, on the date specified by the State.
2. The State shall notify the applicant of enrollment with the Contractor and the effective date of coverage by the Contractor. Except for infants born to women enrolled in the AIM Program and as specified in Item II.B.3., the State shall notify the Contractor of new enrollees no later than ten (10) days prior to the subscriber's effective date of coverage.
3. The Contractor agrees that in special circumstances the State may provide less than ten days' notice prior to a subscriber's effective date of coverage. Special circumstances shall be at the discretion of the State, but Contractor shall be notified of the special circumstance, in writing and electronically when appropriate.

### C. Disenrollment

1. The Contractor agrees to disenroll subscribers when notified to do so by the State, in writing and electronically when appropriate, on the date specified by the State.

2. In no event shall any individual subscriber be entitled to the payment of any benefits with respect to vision care services rendered, supplies or drugs received or expense incurred following termination of coverage consistent with state and federal law. For the purposes of this Agreement, a charge shall be considered incurred on the date the service or supply giving rise to the charge is rendered or received.

D. Commencement of Coverage

Coverage shall commence for a subscriber at 12:01 a.m. on the day designated by the State as the effective date of coverage.

E. Provider Directory and Evidence of Coverage Booklet

1. Except for infants born to women enrolled with the Contractor in the AIM Program and subscribers enrolled with less than ten days' notice pursuant to Item II.C.3., the Contractor shall, no later than the effective date of coverage, issue to applicants on behalf of subscribers an Identification Card, issue or offer a Provider Directory, and issue an Evidence of Coverage booklet setting forth a statement of the services and benefits to which the subscriber is entitled. The Contractor agrees that the materials sent to applicants on behalf of subscribers shall also include information to subscribers regarding how to access services. The information shall be in addition to the description provided in the Evidence of Coverage booklet. Examples of acceptable forms of information include but are not limited to: a brochure on How to Access Services, inclusion in a cover letter of the specific pages in the Evidence of Coverage booklet relating to accessing services, or a magnet listing the telephone number to call to schedule an appointment with a provider. The contractor's Evidence of Coverage booklet, as approved by the State, is hereby incorporated by reference, as fully set forth within.
2. For infants born to women enrolled in the AIM Program with the Contractor and subscribers enrolled with less than ten days' notice pursuant to Item II.C.3., the Contractor shall provide the Identification Card, issue or offer a Provider Directory, and provide an Evidence of Coverage booklet and other materials described in Item II.F.1. to applicants on behalf of subscribers no later than ten (10) days from the date the Contractor is notified of the enrollment.

3.
    - a. In addition to the instances described in Items II.F.1. through II.F.2., above, the Contractor shall, by April 1 of each year, issue or offer to each applicant on behalf of the subscribers enrolled in the Contractor's plan an updated Provider Directory, and issue either an updated Evidence of Coverage booklet (or amended pages) setting forth a statement of the services and benefits to which the subscriber is entitled in the next benefit year, or a letter describing any changes to the benefits package that will go into effect at the beginning of the next benefit year.
    - b. In any year in which an updated Evidence of Coverage booklet (or amended pages) is not issued by April 1, the Contractor shall issue an updated Evidence of Coverage booklet by June 15 to each applicant on behalf of the subscribers enrolled in the Contractor's plan.
    - c. The Contractor shall obtain written approval by the State prior to issuing the updated Evidence of Coverage booklet (or amended pages) and the letter describing changes in the benefit package. The letter shall be submitted to the State by March 1 for review and approval.
    - d. By July 1 of each year, the Contractor shall submit to the State ~~three~~ **two print** copies of the updated Evidence of Coverage booklet (or amended pages), **one electronic copy of the final approved Evidence of Coverage booklet (or amended pages) on compact disk**, and one **print** copy of the updated Provider Directory.
4. The Contractor's Provider Directory shall be updated and distributed by the Contractor to applicants on behalf of subscribers whenever there is a material change in the Contractor's provider network.
5. The Contractor's Provider Directory shall indicate the language capabilities of the providers' offices.
6. The Contractor shall provide a copy of the Contractor's Evidence of Coverage booklet and Provider Directory to any person requesting such materials, by telephone or in writing, within ten (10) days of the request.
7. Written informing material provided to subscribers shall be at a sixth grade reading level or at a level that the Contractor

determines is appropriate for its subscribers and that is approved by the State, to the extent that compliance with this provision does not conflict with regulatory agency directives or other legal requirements.

8. Whenever the Contractor assigns a subscriber to a clinic, the Contractor shall notify the subscriber of his/her right to select a new primary care provider. If a subscriber selects a primary care optometrist who is affiliated with a clinic and the assignment of the subscriber is made to the clinic pursuant to Insurance Code section 12693.515, the Contractor shall inform the subscriber that he/she has been assigned to the clinic and has a right to select a new primary care optometrist immediately or at any future time, including such time as the selected primary care optometrist is no longer affiliated with the clinic. The Contractor shall promptly notify the subscriber of his/her rights after the assignment to the clinic has been made.

F. Right to Services

Possession of the Contractor's Identification Card confers no right to services or other benefits of the Program. To be entitled to services or benefits, the holder of the card must, in fact, be a subscriber enrolled in the Program.

G. Open Enrollment

The Contractor agrees to participate in an annual open enrollment process during which subscribers may transfer between vision plans.

H. Enrollment Data

The State and the Contractor agree to the following regarding the transmission, receipt, and maintenance of enrollment data.

1. The State shall transmit subscriber enrollment and disenrollment information, subscriber data updates, as well as transfer and reinstatement information, to the Contractor using Electronic Data Interchange (EDI) each business day. The Contractor must accept this information via EDI and update its enrollment system within 3 calendar days, excluding holidays. The Contractor shall receive the transmitted information, data and file sent through the EDI in a manner and format that comply with HIPAA standards for electronic transactions and code sets. **The Contractor agrees that the State is the official record holder of subscribers' information and**

**shall not make any changes to Contractor's copy of subscribers' records unless such changes are transmitted by the State.**

2. The Contractor agrees to accept written confirmation of enrollments from the State plan liaisons, in the event system errors cause enrollment transactions to be delayed. The State agrees that the written confirmations are valid and acceptable alternative notifications to the Contractor until the failed or delayed enrollment transaction can be generated and sent to the Contractor.
3. The State shall develop an electronic bulletin board system, available 24 hours a day, excluding maintenance periods that usually will be held on Sundays, to provide the Contractor with enrollment reports.
4. The State shall establish and manage a plan liaison function for the purpose of enhancing the program operations through the sharing and coordination of information with the Contractor. Common or persistent problems or issues with the Contractor shall be communicated to the State. The State shall provide a separate telephone number for communication between the State and the Contractor.
5. The State shall transmit to the Contractor on a weekly basis (on Saturday or Sunday) a separate confirmation file. This shall consist of a record count of the different record types in the weekly enrollment file. The State shall also transmit to the Contractor enrollment and data files on a weekly basis (on Saturday or Sunday) reflecting the prior week's activity. The Contractor shall use the data files to reconcile and validate weekly activity.
6. The State shall complete weekly transmissions by 4:00 a.m. Pacific Standard Time each Monday or, when Monday is an official State holiday, by 4:00 a.m. Pacific Standard Time Tuesday. If the weekly transmission is not completed by the stated time, the State shall promptly notify the Contractor of the date and time when the transmission will be completed.
7. The State shall transmit the files described in Items II.H.1. and II.H.5. to the Contractor at no charge.
8. On a monthly basis, the State shall provide audit files for the Contractor, including, but not limited to, currently active subscribers. The audit files shall normally be provided by the third Monday of the month following the month for which data are being

reported. If unexpected circumstances cause a delay in the provision of the audit files, the State, through the administrative vendor's assigned plan liaison, shall notify the Contractor.

9. The State shall provide, at the Contractor's request, retransmission files of the data files set forth in Item 5 above within six months of the original transmissions. The Contractor agrees to pay for assembly and transmissions costs of the files in Item II.H.5. above at the rate of \$85 per hour or \$250 per report or file, whichever cost is greater.
10. The Contractor agrees to reconcile its enrollment data using the monthly data files sent by the State. The Contractor shall report any enrollment discrepancies to the State, in a format approved by the State, within sixty (60) days from the date the monthly audit file is provided to the Contractor. The State shall not be liable for any discrepancies reported by the Contractor after this 60-day period. The State shall respond to discrepancies timely submitted to the State by the Contractor.
11. With respect to Item II.H.5. above, the Contractor shall utilize the State's plan liaison personnel as much as possible. There will be no charge for the services of the State's plan liaison.
12. Prior to commencing work requested by the Contractor under Items II.H.8. or II.H.9., the State shall provide a cost estimate to the Contractor.
13. The State shall provide EDI instructions and data mapping formats to the Contractor upon request of the Contractor. The State shall provide additional technical assistance, either by telephone or at the Contractor's site, to plans new to EDI data transmission as they establish electronic capability.
14. The State shall conduct at least one meeting for the period of this Agreement for the purpose of providing training and technical assistance to the Contractor regarding EDI and transmission of enrollment data.
15. The Contractor agrees either to use the Program's Family Member Number (FMN) in its data base for subscriber tracking purposes or to maintain a cross reference mechanism between the Contractor's unique identifier and the Program's unique identifier.

I. Network Information Service

1. The Contractor agrees to provide, to the best of the Contractor's ability, complete and accurate data on its provider network in an electronic format to be determined by the State. The information may be expanded by the State with no less than ninety (90) days notice by the State. The Contractor agrees to provide additional data elements, as requested by the State, to the best of its ability. The Contractor understands that the State intends to use information provided pursuant to this section to assist potential and current applicants and subscribers in selecting a vision plan, and that information provided to the State will be shared with the public.
2. The Contractor agrees to provide the provider network information to the State on a quarterly basis, including updated notations on providers accepting new Program subscribers. The Contractor may update its provider network information on a monthly basis. The Contractor is required to provide data for the creation of the database to the State between the 11<sup>th</sup> and 25<sup>th</sup> of any submission month.
3. If the Contractor is unable to provide electronic files in the specified provider network formats, the State agrees to offer the Contractor data capture services at the rate of \$25 per hour.
4. If the Contractor so requests, the State agrees to offer the Contractor an unscheduled update to the provider network information at the rate of \$500 per update.

J. Traditional and Safety Net Providers

The Contractor agrees to establish, with traditional and safety net providers as described in Article 4. of the Program regulations, network membership and payment policies which are no less favorable than its policies with other providers.

K. Public Awareness

1. The Contractor agrees to engage in marketing efforts designed to increase public awareness of and enrollment in the Program. At a minimum these efforts shall include the following activities. The Contractor shall publicize its participation in the Program through its internal provider communications and through its general membership communication publications. All public awareness efforts must be approved by the State before being released in

public and must be in compliance with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments and applicable regulations. In the event that the State does not notify the Contractor in writing, with the reasons the marketing materials are not approved, within sixty (60) days of receipt by the State, the materials shall be deemed approved.

2. The Contractor is prohibited from directly, indirectly, or through their agents, conducting in person, door to door, mail or telephone solicitation of applicants for enrollment.
3.
  - a. By September 1, 2005, the Contractor agrees to submit to the State for its approval, in a format determined by the State, a marketing plan that covers the term of this Agreement.
  - b. The marketing plan shall include the Contractor's mission statement, a written description of proposed marketing activities and locations, a listing of all proposed marketing materials to be used, and proposed locations for distribution, including ancillary components such as scripts. Upon request by the State, the Contractor shall submit other information, such as examples of previously approved marketing materials currently being used.
  - c. The marketing plan shall be in compliance with all applicable statutes and regulations, as well as the Program's marketing guidelines.
4. For the 2006-07 and 2007-08 benefit years, the Contractor agrees to submit to the State, in a format determined by the State, any proposed updates or amendments to its then-approved marketing plan.
5. If the Contractor chooses to provide application assistance, the plan must have an approved application assistance plan on file with the State **and agrees that its designated staff must successfully complete the State's online application assistance training before beginning any application assistance activity.**

### III. CUSTOMER SERVICE

#### A. Telephone Service for Subscribers

The Contractor agrees to provide a toll free telephone number for applicant and subscriber inquiries. This telephone service shall be available on regular business days from the hours of 8:30 a.m. to 5:00 p.m. Pacific Time. The Contractor will provide staff bilingual in English and Spanish during all hours of telephone service. The Contractor shall have the capability to provide telephone services via a interpretive service for all limited English proficient (LEP) persons.

#### B. Grievance Procedure (DMHC)

Department of Managed Health Care Licensees:

1. The Contractor shall establish a grievance procedure to resolve issues arising between itself and subscribers or applicants acting on behalf of subscribers. The Contractor's process shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by Contractor's licensing statute, the Knox-Keene Health Care Service Plan Act of 1975, as amended. These procedures shall be described in the Contractor's Evidence of Coverage booklet.
2. The Contractor shall report to the State by February 1 of each year, in a format determined by the State, the number and types of benefit grievances filed by subscribers and by applicants on behalf of subscribers in the previous calendar year in the Program. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of vision benefits in the Program.

**OR**

#### B. Grievance Procedure (DOI)

Department of Insurance Licensees:

1. The Contractor shall establish a grievance procedure to resolve issues arising between itself and subscribers or applicants acting on behalf of subscribers. The Contractor's process shall include all features required for health care service plans pursuant to the

Knox-Keene Health Care Service Plan Act of 1975, as amended, and shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by the Knox-Keene Act. These procedures shall be described in the Contractor's Certificate of Insurance booklet.

2. The Contractor shall report to the State by February 1 of each year, in a format determined by the State, the number and types of benefit grievances filed by subscribers and by applicants on behalf of subscribers in the previous calendar year in the Program. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of vision benefits in the Program.

C. Cultural and Linguistic Services

1. Linguistic Services

- a. The Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80) which prohibits recipients of federal financial assistance from discriminating against persons based on race, color or national origin. This is interpreted to mean that a limited English proficient (LEP) individual is entitled to equal access and participation in federally funded programs through the provision of bilingual services.
- b. The Contractor shall provide during the hours of 6:00 a.m. to 6:00 p.m. access to interpreter services for all LEP subscribers seeking vision services within the Contractor's network. The Contractor shall use face-to-face interpreter services, if feasible. If face-to-face interpreter services are not feasible, the Contractor may use telephone language lines for interpreter services. The Contractor shall develop and implement policies and procedures for ensuring access to interpreter services for all LEP subscribers, including, but not limited to, assessing the cultural and linguistic needs of its subscribers, training of staff on the policies and procedures, and monitoring its language assistance program. The Contractor's procedures must include ensuring compliance of any subcontracted providers with these requirements. Activities that the Contractor may undertake to assure compliance of subcontracted providers

include, but are not limited to, employing telephone language services, competent bilingual or multilingual staff who can interpret for providers and subscribers, or and using competent contracted community-based organizations for interpreter services.

- c. When the need for an interpreter has been identified by the provider, or when requested by a subscriber the Contractor agrees to provide a competent interpreter for scheduled appointments. The Contractor shall avoid unreasonable delays in the delivery of vision care services to persons of limited English proficiency. The Contractor shall instruct the providers within its provider network to record the language needs of subscribers in the medical record.
- d. The Contractor agrees that subscribers shall not be required or encouraged to utilize family members or friends as interpreters. After being informed of his or her right to use free interpreter services provided by the Contractor, a subscriber may use an alternative interpreter of his or her choice at his or her cost. The Contractor shall encourage the use of qualified interpreters. The Contractor agrees that minors shall not be used as interpreters, except for only the most extraordinary circumstances, such as medical emergencies. The Contractor shall ensure that the request or refusal of language or interpreter services is documented in the medical record. Activities that the Contractor may undertake to ensure compliance of providers with this paragraph include, but are not limited to training its providers on the need to document a request or refusal of interpreter services; supplying providers and their staff with Request/Refusal forms for interpreter services; supply providers and their staff with chart labels identifying member language needs; implementing an incentive program to reward provider offices that affirmatively attempt to identify language needs of LEP members and record them on the medical charts; conducting reviews of providers' medical records during periodic audits and/or facility site reviews to check for documentation of the request for or refusal of interpreter services; and providing other technical assistance to providers.
- e. The Contractor shall inform subscribers of the availability of linguistic services. Information provided to subscribers regarding interpreter services shall include, but not be limited

to, the availability of interpreter services to subscribers at no charge; the right not to use family members or friends as interpreters; the right to request an interpreter during discussions of medical information such as diagnoses of medical conditions and proposed treatment options, and explanations of plans of care or other discussions with procedures; the right to receive subscriber materials as described in Item III.C.2. of this Exhibit; the right to file a complaint or grievance if linguistic needs are not met.

- f. The Contractor shall ensure that there is appropriate bilingual proficiency at medical and non-medical points of contact for providers who list their bilingual capabilities in provider directories. Medical points of contact include advice and urgent care telephone lines and face-to-face encounters with providers who provide medical or health care advice to members. Non-medical points of contact include member/customer service, plan or provider office reception, appointment services, and member orientation sessions. Activities that the Contractor may undertake to ensure the bilingual proficiency of interpreters at medical and non-medical points of contact include, but are not limited to: hiring staff who demonstrate conversational fluency as well as fluency in medical terminology; providing training that will enable staff to take, or assist with gathering, information for an accurate medical history with culturally related consent forms; providing dictionaries and glossaries for interpreters; providing provider staff with consistent interpreter training by experienced and properly trained interpreters; periodically assessing the language proficiency of the plan's identified medical and non-medical staff who have patient contact; conducting audits of provider sites to confirm ongoing language capabilities of providers and staff; and providing other technical assistance to providers.
- g. The Contractor shall identify and report the on-site linguistic capability of providers and provider office staff through the reporting required for the Network Information Service described in Item II.I. of this Exhibit.
- h. If it is determined by the State that the Contractor is not in compliance with the Cultural and Linguistic requirements specified in Section C, Cultural and Linguistic Services, the Contractor shall submit a corrective action plan that corrects

the non-compliance within a time period satisfactory to the State.

2. Translation of Written Materials

- a. The Contractor agrees to translate written informing materials for subscribers including, but not limited to, the Evidence of Coverage booklet; form letters; notice of action letters; consent forms; letters containing important information regarding participation in the health plan; notices pertaining to the reduction, denial, modification, or termination of services; notices of the right to appeal such actions or that require a response from subscribers; notices advising LEP subscribers of the availability of free language assistance services; other outreach materials; and medical care reminders. Written informing materials for subscribers shall be provided at a sixth grade reading level or as determined appropriate through the Contractor's Cultural and Linguistic Needs Assessment and approved by the State, to the extent that compliance with this requirement does not conflict with regulatory agency directives or other legal requirements. Translation of these materials shall be in the following languages: Spanish, and any language representing the preferred mode of communication for the ~~lesser of~~ either five percent (5%) or more of the Contractor's enrollment or 3,000 or more subscribers of the Contractor's enrollment in the Program as of December 1 of the previous year. In addition, if the State includes the subscriber's preferred written language in the enrollment file sent to the Contractor, and that language is Spanish or the preferred mode of communication for either five percent (5%) or more of the Contractor's enrollment or 3,000 or more subscribers of the Contractor's enrollment in the Program, Contractor shall provide materials in that language. If the Contractor serves both Medi-Cal and Program subscribers, it is encouraged, where practicable, to translate Program member materials into additional Medi-Cal threshold languages not required by the Program. The Contractor shall ensure that members who are unable to read the written materials that have been translated into non-English languages have an alternate form of access to the contents of the written materials. Activities that the Contractor may undertake to comply with this paragraph include, but are not limited to, informing LEP subscribers, during the welcome

call, of the plan's language assistance services; encouraging members to call the Contractor if they need help in understanding any of the Contractor's written materials; providing an oral translation of the material in a member's preferred language or arranging for this to be done by a competent interpreter service; and making the content of the written materials available in alternative formats such as Braille, CD, and audio cassette.

- b. The Contractor shall ensure the quality of the translated material. The Contractor is encouraged to use different qualified translators during sequential levels of the translation process to ensure accuracy, completeness and reliability of translated materials. The Contractor agrees that the translation process shall include the use of qualified translators for translating and editing, proofreading and professional review. Activities that the Contractor may undertake to ensure the quality of translated materials include, but are not limited to, contracting and using certified translation companies that follow a step-by-step translation process; performing back translation of material into its source language for comparison and accuracy by certified translation vendors other than the original translator; having an internal team review committee that includes a medical and/or legal "professional reviewer" who reviews translated materials for cultural appropriateness; and proof-reading and editing of the document by a separate qualified translation editor/proof reader. The Contractor may use computer technology as part of the process for producing culturally and linguistically appropriate translation. Guidelines for developing and producing culturally and linguistically appropriate translations and definitions for the terms used are included in Attachment III, Translated Process Flowchart.
- c. By September 30 of each year, the Contractor shall submit to the State one copy of only those materials that, pursuant to Item II.E., are routinely provided to new subscribers for each language in which the materials are translated.

3. Cultural and Linguistic Group Needs Assessment

- a. By June 30, 2007, the Contractor agrees to conduct and submit to the State a Cultural and Linguistic Needs Assessment to promote the provision and utilization of

appropriate services for its diverse enrollee population. The Needs Assessment report shall include findings from the assessment described in Item III.C.3.b. below and a plan outlining the proposed services to be improved or implemented as a result of the assessment findings, with special attention to addressing cultural and linguistic barriers and reducing racial, ethnic, and language disparities.

- b. The Cultural and Linguistic Needs Assessment shall examine the demographic profile of the Contractor's Program enrollees by ethnicity and language to assess their linguistic and cultural needs. The assessment shall be conducted in accordance with guidelines issued by the State and shall examine the language preference of the Program enrollees and other data, including, but not limited to, the health risks, beliefs, and practices of the Contractor's enrollees. The Contractor may conduct the Needs Assessment individually or collaboratively with other plans participating in the Program.
- c. The Contractor shall assess the internal systems it has in place to address the cultural and linguistic needs of its Program enrollment population, including, but not limited to, assessing the Contractor's capacity to provide linguistically appropriate services. The Contractor shall review internal data including complaints and grievances, results from member surveys, diversity and language ability of staff as reflective of the enrollee population, internal policies and procedures, education and training of staff and providers regarding cultural and linguistic competency issues, and, to the extent feasible, utilization and outcome data analyzed by race, ethnicity and primary language. This information shall be examined in relation to and compared with external data for benchmarking and trends.
- d. The Contractor agrees to provide an opportunity for representatives of subscribers enrolled in the Program to provide input on the Cultural and Linguistic Needs Assessment. The Contractor may use an existing member advisory committee or community advisory committee for the purposes of providing an opportunity for Program subscribers to provide input. The Contractor shall ensure that the committee used to obtain input from subscribers is representative of subscribers in the program and includes representatives from hard-to-reach populations. The

Contractor shall also ensure that the committee holds regular meetings and is provided with adequate resources to support committee activities and support staff.

4. Operationalizing Cultural and Linguistic Competency

- a. The Contractor shall develop internal systems that meet the cultural and linguistic needs of the Contractor's subscribers in the Program. The Contractor shall provide initial and continuing training on cultural competency to staff and providers. Ongoing evaluation and feedback on cultural competency training shall include, but not be limited to, feedback from subscriber surveys, staff, providers, and encounter/claims data.
- b. Activities that the Contractor may undertake in developing its internal systems to meet the cultural and linguistic needs of the Contractor's subscribers include: incorporating cultural competency in the Contractor's mission; establishing and maintaining a process to evaluate and determine the need for special initiatives related to cultural competency; developing recruitment and retention initiatives to establish organization-wide staffing that is reflective and/or responsive to the needs of the community; assessing the cultural competence of plan providers on a regular basis; establishing a special office or designated staff to coordinate and facilitate the integration of cultural competency guidelines; providing an array of communication tools to distribute information to staff relating to cultural competency issues (e.g., those tools generally used to distribute other operational policy-related issues); participating with government, community, and educational institutions in matters related to best practices in cultural competency in managed vision care to ensure that the Contractor maintains current information and an outside perspective in its policies; maintaining an information system capable of identifying and profiling cultural and linguistic specific patient data; and evaluating the effectiveness of strategies and programs in improving the health status of cultural-defined populations.
- c. The Contractor shall report, on or before December 10 of each year, the linguistically and culturally appropriate services provided and proposed to be provided to meet the needs of limited-English proficient applicants and subscribers in the Program. This report shall address types

of services including, but not limited to linguistically and culturally appropriate providers and clinics available, interpreters, marketing materials, information packets, translated written materials, and referrals to culturally and linguistically appropriate community services and programs, and training and education activities for providers. The Contractor shall also report its efforts to evaluate cultural and linguistic services and the outcomes of cultural and linguistic activities as part of the Contractor's ongoing quality improvement efforts. Reported information may include member complaints and grievances, results from membership satisfaction surveys, and utilization and other clinical data that may reveal health disparities as a result of cultural and linguistic barriers. The report shall also address activities undertaken by the Contractor to develop internal systems, as described in Item III.C.4.b. of this Exhibit. The Contractor shall also report on the status of the Contractor's cultural and linguistic activities developed from the Needs Assessment. The format for this report shall be determined by the State.

#### IV. COVERED SERVICES AND BENEFITS

##### A. Covered and Excluded Benefits

1. **Except as required by any provision of applicable law, the** ~~Only~~ ~~those~~ benefits described in Article 3. Sections 2699.6721 and 2699.6723, of the Program regulations shall be covered benefits under the terms of this Agreement. Except as required by any provision of applicable law, those benefits excluded in Article 3. of the Program regulations shall not be covered benefits. The Contractor shall set out the plan of coverage in an Evidence of Coverage booklet.
2. The parties understand that terms of coverage under this Agreement are set forth in the attached Evidence of Coverage booklet, hereby incorporated by reference, as fully set forth within. In the case of conflicts, terms of coverage set forth in the Evidence of Coverage booklet shall be binding notwithstanding any provisions in this Agreement which are less favorable to the subscriber.

3. The Contractor shall make benefit and coverage determinations. All such determinations shall be subject to the Contractor's grievance procedures.

B. California Children's Services (CCS)

1. Once CCS eligibility is determined as defined in Title 22, CCR, Section 41518, medically necessary vision services that are authorized by the CCS Program to treat a subscriber under the age of nineteen (19) for CCS eligible conditions as per Section 41800 et seq., are not covered under this Agreement. The Contractor shall identify subscribers with suspected CCS eligible vision conditions and shall refer them to the local CCS office or primary care provider (PCP) for determination of medical eligibility by the CCS Program. Upon referral, the Contractor shall provide the applicant on behalf of the subscriber with a California Children's Services one page (double sided) informational flyer. The State agrees to provide the Contractor with camera ready copies of the California Children's Services informational flyer.
2. The Contractor shall implement written policies and procedures for identifying and referring subscriber with suspected CCS eligible vision conditions to the local CCS Program or the PCP. The policies and procedures shall include, but not be limited to:
  - a. Procedures for ensuring that the Contractor's providers are informed of the procedures to make a referral to the local CCS program.
  - b. Policies and operational controls that ensure that the Contractor's providers document referral to CCS by adding the providers' notes that indicate reasons for referral to the CCS program.
  - c. Procedures that provide for continuity of care between the Contractor's providers and CCS providers.
3. The Contractor shall report to the State the number of subscribers who were referred to the local CCS Program. The report is due by July 31 of each year. The format for the report shall be determined by the State.
4. The Contractor shall consult and coordinate CCS referral activities with the local CCS Program in accordance with the required

Memorandum of Understanding (MOU) between the Contractor and the local CCS Program.

5. Until eligibility for the CCS Program is established, the Contractor shall continue to be responsible for arranging for the delivery of all covered medically necessary vision care and case management services for a subscriber referred to CCS. Services which are provided by a CCS paneled provider or approved facility on the date of referral, or afterwards, and which are authorized by the CCS program for a CCS eligible child, shall be paid by the CCS program at the CCS reimbursement rate retroactively to the provider of services.
6. Once eligibility for the CCS Program is established for a subscriber the Contractor shall continue to provide primary vision care unrelated to the CCS eligible condition and shall ensure the coordination of services between its primary care providers, the CCS specialty providers and the local CCS Program.
7. *(For plans not participating in the Program prior to July 1, 2005)* By July 1, 2005, the Contractor agrees to develop and submit to the State a signed Memorandum of Understanding (MOU) with the local CCS program in each county in which the Contractor participates in the Program. The MOU shall include the policies and procedures described in Item IV.B.2. The Contractor is willing to sign the draft MOU developed by the State. If the Contractor is unable on July 1, 2005 to submit an MOU signed by both the Contractor and local CCS program, the Contractor agrees to report, in writing, to the State on the first day of each month on the Contractor's progress in obtaining a signed MOU.

C. Other Public Linkages

The Contractor shall, to the extent feasible, create viable protocols for screening and referring subscribers needing supplemental services outside of the scope of benefits described in Article 3. of the Program regulations to public programs providing such supplemental services for which they may be eligible, as well as for coordination of care between the Contractor and the public programs. Public programs may include but not be limited to: regional centers, programs administered by the Department of Alcohol and Drug Programs, Women, Infants and Children Supplemental Food Program (WIC), lead poisoning prevention and programs administered by local education agencies.

D. Pre-existing Condition Coverage Exclusion Prohibition

No pre-existing condition exclusion period or post-enrollment waiting period shall be required of subscribers.

E. Exercise of Cost Control

The Contractor shall enforce all contractual agreements for price and administer all existing utilization control mechanisms for the purpose of containing and reducing costs.

F. Copayments

1. The Contractor shall impose copayments for subscribers as described in Article 3. of the Program regulations.
2. The Contractor shall work with its provider networks to provide for extended payment plans for subscribers utilizing a significant number of vision services for which copayments are required. When feasible, the Contractor shall instruct its provider network to offer extended payment plans whenever a family's copayments exceed twenty-five dollars (\$25) in one month.
3. The Contractor shall report the copayments paid by a list of subscribers provided by the State in the previous benefit year by October 1 of each year. The format for the report shall be determined by the State.
4. The Contractor shall implement an administrative process that assures that all copayments are waived for American Indian and Alaska Native subscribers in the Program, if the State identifies such subscribers as qualifying for the waiver.

G. Coordination of Benefits

The Contractor agrees to coordinate benefits with other group vision plans or insurance policies for subscribers in the Program. The Contractor agrees to work with other plans or insurers to provide no more than one-hundred percent (100%) of subscribers' covered vision expenses. The Contractor shall coordinate such that coverage provided pursuant to this Agreement is secondary to all other coverage except for Medicaid (Medi-Cal).

H. Acts of Third Parties

If a subscriber is injured through the wrongful act or omission of another person, the Contractor shall provide the benefits of this Agreement and the subscriber or applicant on behalf of a subscriber shall be deemed:

1. To have agreed to reimburse the Contractor to the extent of the reasonable value of services allowed by Civil Code Section 3040, immediately upon collection of damages by him or her, whether by action at law, settlement or otherwise, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement; and
2. To have provided the Contractor with a lien to the extent of the reasonable value of services provided by the Contractor and allowable under Civil Code section 3040, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement. The lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

I. Workers' Compensation Insurance

If, pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of vision services provided by the Contractor, then the Contractor shall provide the benefits of this Agreement and the subscriber shall be deemed to have provided the Contractor with a lien on such Workers' Compensation medical benefits to the extent of the reasonable value of the services provided by the Contractor. The lien may be filed with the responsible third party, his or her agency, or the court. For purposes of this subsection, reasonable value shall be determined to be the usual, customary or reasonable charge for services in the geographic area where the services are rendered.

J. Use of Subcontractors

The Contractor may, in its discretion, use the services of subcontractors to recover on the liens provided for under Items IV.H. and IV.I. of this Exhibit. The subcontractor's compensation may be paid out of any lien recoveries obtained. The State understands and agrees that lien recoveries are chargeable with a prorata contribution toward the injured person's attorney fees under the Common Fund Doctrine. The Contractor may compromise liens as may be reasonable and appropriately consistent with normal business practices.

K. Interpretation of Coverage

The Contractor, in its Evidence of Coverage booklet (Attachment V), shall provide clear and complete notice of terms of coverage to subscribers. In the event of ambiguity regarding terms of coverage, the Contractor shall interpret those terms in the interest of the subscriber. In the event of ambiguity regarding an exclusion from coverage, the Contractor shall interpret the language of the exclusion in the interest of the subscriber. Nothing in this provision shall supersede the common law rules for interpretation of insurance contracts.

V. DATA REPORTING

A. Electronic Data Transfer

The Contractor agrees to establish and maintain, in a manner and format to be specified by the State and agreed to by the Contractor, the capability to transmit the data specified in Item II.I. to the State using electronic media. The transmission shall be in a manner and form that comply with HIPAA standards for electronic transactions and code sets.

B. Claims and Encounter Data

The Contractor understands that the State intends to collect claims and encounter data from the Contractor during the 2006-07 contract year.

C. The Contractor understands that the State will evaluate the plan's customer satisfaction survey results annually and will take appropriate action if the State determines that the Contractor's continued participation in the Healthy Families Program is not in the best interest of its subscribers.

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## **EXHIBIT B BUDGET DETAIL AND PAYMENT PROVISIONS**

### **I. PAYMENT PROVISIONS**

The Contractor agrees to arrange for the provision of vision benefits and case management services for subscribers in the Program as described in Exhibit A, Section IV. of this Agreement.

#### **A. Fees Provided to Contractor**

1. As specified in Items I.B. of this Exhibit, the State shall pay the Contractor a flat fee per month per subscriber child for all services received by the subscriber child. These fees are set forth in Attachment V, Confidential Rates of Payment.
2. In cases of subscriber eligibility and enrollment appeals, which results in liability of vision care costs by the State, the Contractor shall pay the provider for services delivered within 30 days following notification by the State of the appeal findings and shall claim reimbursement from the State within 45 days after notification by the State of the appeal findings. The State shall pay the Contractor the actual costs paid by the Contractor for services received. The Contractor shall reimburse and claim for such services at any discounted rate that the Contractor may have in place for the provider in the program and that is accepted by the provider as payment in full. Such payments may only be made by the Contractor and paid by the State when the Contractor receives prior written direction from the State.

#### **B. Payment Schedule**

1. For the first month or partial month of a subscriber's coverage the State agrees to pay one hundred percent (100%) of the fee described in Item I.A. of this Exhibit for subscribers with effective dates of coverage on the first (1st) through fifteenth (15th) day of the month. No fee shall be paid for the first partial month of coverage for subscribers whose coverage begins on the sixteenth (16th) through thirty-first (31st) day of the month. The State agrees to pay the fee within fifteen (15) days after the completion of the month of coverage.
2. For all months of coverage after the first month in which a subscriber's coverage becomes effective, the State agrees to pay the fee described in Item I.A. of this Exhibit. The State agrees to

pay the fee within fifteen (15) days after the completion of the month of coverage.

C. Special Enrollment Materials Cost

In any event of an assignment of this Agreement or other transaction through which any entity purchases or otherwise acquires the Contractor's program enrollment, an early termination, or the removal of coverage in a service area by the Contractor which requires a special open enrollment, the Contractor agrees to pay the State for actual costs or \$9.00 per affected subscriber, whichever is greater, for subscribers enrolled in the Contractor's plan who must be moved to another participating plan.

The Contractor understands that the State does not intend to permit any special open enrollment between March 1 and June 30 of any year. Nothing in this Item I.C. shall be construed to limit the State's sole discretion to disapprove any proposed assignment pursuant to Item III of Exhibit C.

II. FISCAL CONTROL PROVISIONS

A. Minimum Loss Ratio

1. The Contractor agrees that administrative costs shall be reasonable. The Contractor agrees that, once the Contractor's plan has a minimum of 1,000 enrolled subscribers per month for six or more months of a benefit year, the minimum loss ratio for services provided to all subscribers pursuant to this Agreement shall be \_\_\_\_%. For reporting purposes, the Contractor's loss ratio shall be calculated in aggregate for all subscribers, using the following formula:

a/b

Where "a" is : Total covered benefit and service costs of Contractor including incurred but not reported claim completion costs minus subscriber co-payment requirements and minus amounts recovered pursuant to Exhibit A, Items IV.I, IV.J. and IV.K. of this Agreement, and

where "b" is : Total premiums received by the Contractor.

2. The Contractor shall report the previous benefit year's loss ratio, as well as an interim loss ratio for July through November of the current year, by January 1 of each year.

3. The Contractor understands that the State may make the results of the loss ratio report listed in Item 2. above available to the public.
4. As part of evaluating the quality of the Contractor's operations, the State has established a goal to ensure one evaluation of the Contractor's reported loss ratio is completed on behalf of the Contractor during the three year term of this Agreement. The evaluation will be done in accordance with standards and procedures for audits, reviews, examinations and evaluations set forth in Exhibit D., Item II.D. of this Agreement. The State will notify the Contractor if the Contractor will be scheduled for an evaluation during the contract year. The State will work with the Contractor regarding scheduling evaluation dates. The State will contract on behalf of the Contractor for the performance of the evaluation. The evaluations will be performed by the California Department of Managed Health Care or a qualified entity to be selected by the State. The State will pay the Department of Managed Health Care or selected qualified entity on behalf of the Contractor for the cost of the loss ratio evaluation.
5. The Contractor agrees that if the evaluation described in Item II.A.4 determines that (i) the minimum loss ratio is less the ratio specified in Item II.A.1, and (ii) the Contractor made a net profit in connection with the services provided, the Contractor shall credit the State with the amount of net profit. The amount of net profit shall be the amount determined as such by the results of the evaluation described in Item II.A.4.
6. The Contractor shall credit the State with the amount of net profit described in Item II.A.5.a as follows:
  - =  
a. Commencing with the first month after the completion of the evaluation described in Item II.A.4 and written notification to the Contractor, the credit of the amount of net profit described in Item II.A.5 shall be applied to the amounts due pursuant to Item I.B until the amount of the credit is entirely exhausted.
  - =  
b. If this Agreement is terminated prior the application of credits described in Item II.A.5, then within thirty (30) days of the receipt by the Contractor of written notification of the amounts of the net profit determined by the evaluation described in Item II.A.4, the Contractor shall pay the State such amounts.

B. Payment Limitation

1. Only subscribers for whom a premium is paid by the State to the Contractor are entitled to vision services and benefits provided hereunder and only for services rendered or supplies received during the period for which the subscriber is enrolled.
2. The Contractor agrees to reconcile, on at least a monthly basis, eligibility data provided by the State with the Contractor's data on persons for whom claims, capitation payments, and other payments related to services and benefits were made in the Program. The Contractor shall make any necessary adjustments indicated by the reconciliation to ensure compliance with Item II.B.1. The Contractor shall maintain records of these reconciliations in accordance with Exhibit D, Item II.C. of this Agreement. The Contractor shall ensure that only the costs of services and benefits covered in the Program are included in the numerator of the loss ratio calculation set forth in Item II.A.
3. The State shall not be liable for any reconciliation discrepancies reported by the Contractor more than sixty (60) days from the date the monthly audit file is provided to the Contractor, pursuant to Exhibit A, Item II.H.10.

C. Availability of Federal Funds

1. It is mutually understood between the parties that this Agreement may have been written for the mutual benefit of both parties **based on then-existing regulations and federal executive agencies' interpretation and application of relevant statutes but** before ascertaining the availability of Congressional appropriation of funds, **in order** to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.
2. This Agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the purposes of this Program for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions **made applicable at any time by:**
  - a. ~~enacted by the~~ **enactments of** Congress or

- b. regulations promulgated or amended by federal executive agencies, or
- c. the interpretation or application by federal executive agencies of relevant regulations and statutes

~~to any statute enacted by the Congress that may affect the provisions, terms or funding of this Agreement in any manner.~~

- 3. The parties mutually agree that, if Congress does not appropriate sufficient funds for the Program or, as described in Exhibit B, Items II.C.2.a., b. and c., restrictions, limitations or conditions affect the provisions, terms or funding of this Agreement, this Agreement shall be amended to reflect any reduction in funds and any restrictions, limitations, or conditions that affect the Agreement's provisions, terms or funding.
- 4. The State has the option to invalidate this Agreement under the 30 day termination clause in Exhibit D, Item I.B. or to amend the Agreement to reflect any reduction in funds.

D. Prior to Fiscal Year/Crossing Fiscal Years

It is mutually agreed between the parties that this Agreement may have been signed and executed prior to the start of the 2005-06 State Fiscal Year, before ascertaining the availability of funds for the 2005-06 State Fiscal Year. This Agreement has also been written with a term that crosses State Fiscal Years, and therefore before ascertaining the availability of legislative appropriation of funds for the 2006-07 and 2007-08 State Fiscal Years. This Agreement is valid and enforceable only if sufficient funds are made available through the 2006-07 and 2007-08 State Budgets for the purposes of this Program. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted in statute by the State Legislature which may affect the provision, term or funding of this Agreement in any manner. It is mutually agreed that if the State Legislature does not appropriate sufficient funds for this Program, the Agreement shall be amended to reflect any reduction in funds and enrollment shall be curtailed by the State proportionately.

E. Healthy Families Fund Encumbrance

There is no specific maximum amount assigned to this Agreement. Rather, the Contractor is paid through a general encumbrance from the Healthy Families Fund apportioned to the Contractor on an as needed basis. Payments under this Agreement are limited to the provisions of Items I.A. and I.B. of this Exhibit.

F. Fiscal Solvency (DMHC)

The Contractor agrees that it shall at all times maintain the reserves required under the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations promulgated thereunder by the Department of Managed Health Care, including the Tangible Net Equity regulations.

Evidence of above solvency shall be made available to the State upon request.

OR

F. Fiscal Solvency (DOI)

The Contractor agrees that it shall at all times comply with all solvency requirements of its licensing statute and regulations and shall at all times maintain one of the following:

- a. A rating of A+ under Best's insurance rating, or
- b. A surplus capable of paying one month of the Contractor's paid claims. The amount of one month of the Contractor's paid claims shall be established by averaging claims paid in each of the previous twelve (12) months.

Evidence of above solvency shall be made available to the State upon request.

G. Federally Funded Program (Medicare and Medicaid)

The Contractor shall remain in good standing with the State Department of Health Services for services provided to Medi-Cal subscribers with the federal Centers for Medicare and Medicaid Services for services provided to Medi-Cal or Medicare subscribers, and with the Office of the Inspector General of the Department of Health and Human Services. On request, the Contractor agrees to provide the State immediately with copies of all correspondence received from the Department of Health Services, the Centers for Medicare and Medicaid Services, and the Office of the Inspector General of the Department of Health and Human Services which pertains to the Contractor's standing with the respective departments. In addition, the Contractor shall immediately notify the State of any investigations in which there are allegations related to fraud, including but not limited to: 1) the receipt of an administrative subpoena from any state or federal agency, unless the Contractor is advised that it is not the target or subject of the investigation; 2) the receipt of a grand jury subpoena from

any state or federal court, unless the contractor is advised that it is not the target or subject of the investigation; 3) the execution of a search and seizure warrant at any of the contractor's offices or locations related to such investigations; and 4) the filing of any charges against the contractor in any state or federal court related to such investigations. The Contractor shall immediately notify the State if the Contractor receives a letter of pending sanction or formal corrective action (such as corrective action addressing audit findings or systemic problems) from the State Department of Health Services, the Centers for Medicare and Medicaid Services, or the Office of the Inspector General of the Department of Health and Human Services.

H. Licensing Sanction Notifications (DMHC)

The Contractor agrees that it shall remain in good standing with the Department of Managed Health Care. On request, the Contractor agrees to provide the State with copies of all correspondence from the Department of Managed Health Care that pertains to the Contractor's standing with its regulatory entity. The Contractor shall immediately notify the State if the Contractor receives a letter of pending sanction or formal corrective action (such as corrective action addressing audit findings or systemic problems) from the Department of Managed Health Care.

OR

H. Licensing Sanction Notifications (DOI)

The Contractor agrees that it shall remain in good standing with the Department of Insurance. The Contractor agrees to provide the State with copies of all correspondence from the Department of Insurance that pertains to the Contractor's standing with their regulatory entity. The Contractor shall immediately notify the State if the Contractor receives a letter of pending significant sanction or corrective action from the Department of Insurance.

I. Contractor Performance Standards, Liquidated Damages And Remedy For Non-Performance

1. The State shall monitor the Contractor's compliance with the terms of this Agreement. The State shall attempt to work with the Contractor to assist the Contractor in fulfilling its obligations under this Agreement.
2. If the State finds the Contractor to be out of compliance with the terms of the Agreement, the State may, after thirty (30) days written notice to the Contractor and an opportunity to cure such non-

compliance or default within that thirty (30) day period, suspend thereafter enrollment of eligible subscribers in the Contractor's vision plan. Notice provided to the Contractor pursuant to this section shall include a description of those actions/standards the Contractor must achieve for enrollment to be resumed. Resumption of enrollment is at the discretion of the State.

3. The State and the Contractor agree that the following sections of this Agreement contain objective performance standards to be met by the Contractor, which shall be monitored by the State:
  - a. Exhibit A, Item II.E. Provider Directory and Evidence of Coverage Booklet
  - b. Exhibit A, Item III.A. Telephone Services for Subscribers
  - c. Exhibit A, Item III.B.2. Grievance Report
  - d. Exhibit A, Item III.C.4.c. Cultural and Linguistic Services Report
  - e. Exhibit A, Item IV.B.3. California Children's Services Report
  - f. Exhibit B, Item II.A. Minimum Loss Ratio Report
  - g. Exhibit B, Item II.B.2. Payment Limitation Reconciliation
4. If, in the State's view, the Contractor has not fulfilled its contractual responsibilities with regard to one or more of the items identified in 3. above, the State shall notify the Contractor in writing of the Contractor's lack of performance. If the Contractor does not improve performance to an acceptable level within 5 business days after receipt of such notice, the State may impose liquidated damages on the Contractor of no more than five percent (5%) per day of the Contractor's average daily fee per day beginning on the sixth business day following notification. If the Contractor's performance does not improve within 15 additional business days from the first day liquidated damages were imposed, the State after written notice to the Contractor, may increase the liquidated damages to ten percent (10%) per day of the Contractor's average daily fee per day beginning on the 16th business day following the receipt of notification of non-performance until the Contractor is in compliance with the Contract. The Contractor's average daily fee is calculated by taking the Contractor's total monthly premium and dividing by the number of calendar days in that particular month. In

no event shall the total amount of liquidated damages imposed for the items identified in 3. above exceed ten percent (10%) per day.

5. All liquidated damages must be paid to the State within ten (10) calendar days of receipt of an assessment letter.
6. If the State determines that the Contractor's non-performance was caused in whole or in part by the State, the State shall reduce the damages proportionately.
7. The parties agree that the damages for failure to provide the deliverables and/or meet the contractual performance standards described herein are not susceptible to exact calculation in advance and that the liquidated damage amounts specified in this Agreement represent an agreed estimate of what the future damages would be. These liquidated damages are not intended to be penalties.

J. Licensure (DMHC)

Department of Managed Health Care Licensees:

The Contractor assures the State that it has a license to provide services under this Agreement from its regulatory agency, the Department of Managed Health Care.

**OR**

J. Licensure (DOI)

Department of Insurance Licensees:

The Contractor assures the State that it has a license to provide services under this Agreement from its regulatory agency, the Department of Insurance.

**Attachment I**  
**Instructions for Completing the Healthy Families Program**  
**Plan Coverage Area Workbook**

A customized Plan Coverage Area Workbook for the 2008-09 benefit year will be emailed to each plan separately by **October 31, 2007**. The workbook contains several worksheets that outline your existing coverage area(s), and also contains instructions on how to identify changes to your plan's existing coverage area(s) for the upcoming 2008-09 benefit year. You must e-mail a copy of the completed workbook by **December 7, 2007** to: [HFPContract08@mrrib.ca.gov](mailto:HFPContract08@mrrib.ca.gov).

**Note: MRMIB must receive confirmation that you have obtained regulatory approval for any expansion areas. Confirmation of your regulatory approval from DMHC should be sent via email to [HFPContract08@mrrib.ca.gov](mailto:HFPContract08@mrrib.ca.gov) no later than March 14, 2008. If your regulatory approval for expansion areas is not received by MRMIB by March 14, 2008, MRMIB reserves the right, at its sole discretion, to not include the expanded coverage areas in your 2008-09 contract amendment.**

**Instructions for the Healthy Families Program  
Plan Descriptions, Frequently Asked Questions (FAQ) Chart and Language Grid**

Your Plan Description, FAQ Chart and Language Grid from the 2007-08 Handbook will be e-mailed to you by Wednesday October 31, 2007. Please identify if any changes are needed to these documents by placing a check mark on the appropriate line below.

**Plan Description**

\_\_\_\_\_ We do not have changes for the current plan description.

\_\_\_\_\_ We have made the enclosed changes to the current plan description.

**FAQ Chart**

\_\_\_\_\_ We do not have changes for the current FAQ chart.

\_\_\_\_\_ We have made the enclosed changes to the current FAQ chart.

**Language Grid**

\_\_\_\_\_ We do not have changes for the language grid

\_\_\_\_\_ We have made the enclosed changes to the language grid

Plan Contact Information	
Name:	_____
E-mail address:	_____
Telephone Number:	_____
Fax Number:	_____
Date of submission:	_____

**How to update the documents**

Your **Plan Description** will be emailed to you in Microsoft *Word* format. Your **FAQ chart** and **Language Grid** will be emailed in Microsoft *Excel* format. If you don't have any changes, check the appropriate line above. Read below for more instructions.

By **December 7, 2007**, e-mail the cover page of these instructions and any changes to your Plan Description, FAQ Chart and Language Grid to [HFPContract08@mrmib.ca.gov](mailto:HFPContract08@mrmib.ca.gov) for approval.

**Plan Description** - Any changes to your current plan description should be consistent with the following:

### 1. Plan Description Length and Typeface

Plan descriptions must be limited to no more than 310 words. Descriptions that are too long will be revised. The font and font size can be no smaller than Times 10 point. Plans will have the opportunity to review the revised information and layout in the HFP Handbook before the final production. Please note that additional changes will **not** be accepted during this review.

### 2. Plan logo, toll-free numbers, and language capabilities

The plan logo should appear in the designated 1" x 2 ¾ " space on the page. The toll-free phone number should appear under the logo and all toll-free numbers for each service area or different services should be included. Also, please include the phone hours, days of operation and language capabilities. (See sample below)

**LOGO**  
1-800-111-2222  
Call 7am to 7pm  
English and Spanish

### 3. Text to be included

- **Why choose your plan:** provide highlights about your plan including, but not limited to: customer service, number of HFP providers-pharmacies-hospitals in your network, health and wellness programs, etc.
- **How the plan works:** provide a clear and concise description for this section. This should be the longest section.
- **How to choose:** provide brief instructions on how to select your plan.

**FAQ Chart and Language Grid** - The FAQ chart and Language Grid appear on two separate tabs in one Excel file. The FAQ chart will prompt you to choose your responses from a drop-down list of answers next to each question. The Language Grid includes your threshold languages for printed materials from the 2007-08 benefit year. Update the Grid with any changes by using the *Track Changes* feature in Excel. Refer to Exhibit A, Scope of Work, Section III. C.(2)(a) for information on how to calculate threshold languages.

**Healthy Families Program  
Vision Plan  
Evidence of Coverage (EOC) or Certificate of Insurance (COI) Instructions**

Indicate any changes to your current (2007-08) EOC/COI by submitting **only** the pages with changes indicated on them, **not** your entire EOC/COI. When submitting the changes, include the entire page that will be changed so we can review the change in context. Use ~~striethrough~~ for text you are deleting and underline text you are adding. Additionally, provide a separate document summarizing the changes your plan is proposing, including the page number and an explanation for each change.

You are highly encouraged to use MRMIB's model HFP EOC/COI as a guide, which is available upon request via email at [HFPContract08@mrmib.ca.gov](mailto:HFPContract08@mrmib.ca.gov).

**Deadlines**

By **December 7, 2007**, email any changes to your 2007-08 EOC/COI that you want reflected in your 2008-09 EOC/COI along with a document summarizing the changes for approval to [HFPContract08@mrmib.ca.gov](mailto:HFPContract08@mrmib.ca.gov).

By **April 2, 2008**, mail an updated Provider Directory to members and either a final 2008-09 EOC/COI or a letter describing the 2008-09 benefit changes. (NOTE: if you are sending a letter to your members describing the 2008-09 changes, MRMIB must approve the letter first)

By **June 13, 2008**, mail a final 2008-09 EOC/COI to your members, if you have not done so already.

By **July 3, 2008**, mail two (2) final, bound copies of your 2008-09 EOC/COI, one (1) electronic copy of your final EOC/COI on a CD, and one copy of your Provider Directory to MRMIB.

By **September 26, 2008**, mail a copy of the translated member packets to MRMIB.

All documents related to your 2008-09 EOC/COI submission should be sent to:

Managed Risk Medical Insurance Board  
Attn: Willie Sanchez  
1000 G Street, Suite 450  
Sacramento, CA 95814

When e-mailing documents, please send them to: [HFPContract08@mrmib.ca.gov](mailto:HFPContract08@mrmib.ca.gov).

## Healthy Families Program Vision Plan Fact Sheet

### 2008-09 Contract Period

**NOTE: The Fact Sheet must be emailed by December 7, 2007 to:**

[HFPCContract08@mrmib.ca.gov](mailto:HFPCContract08@mrmib.ca.gov)

**If you have any questions regarding this form, please contact Willie Sanchez at (916) 323-2072.**

Plan Name: \_\_\_\_\_

Plan contact person for follow up information: \_\_\_\_\_  
(Name and phone number)

1. Please complete the Optometrists chart below.

Optometrists	2005	2006	2007
Total number of optometrists in the provider network as of January 1 <sup>st</sup> for the calendar year.	# _____	# _____	# _____
Number of optometrists added to the provider network during the calendar year. (Indicate number and percentage.)	# _____	# _____	# _____
	% _____	% _____	% _____
Number of optometrists that left the provider network during the calendar year. (Indicate number and percentage.)	# _____	# _____	# _____
	% _____	% _____	% _____
Total number of optometrists in the provider network as of December 1 <sup>st</sup> .	# _____	# _____	# _____

2. Please complete the Ophthalmologists chart below.

<b>Ophthalmologists</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Total number of ophthalmologists in the provider network as of January 1 <sup>st</sup> for the calendar year.	# _____	# _____	# _____
Number of ophthalmologists added to the provider network during the calendar year. (Indicate number and percentage.)	# _____	# _____	# _____
	% _____	% _____	% _____
Number of ophthalmologists that left the provider network during the calendar year. (Indicate number and percentage.)	# _____	# _____	# _____
	% _____	% _____	% _____
Total number of ophthalmologists in the provider network as of December 1 <sup>st</sup> .	# _____	# _____	# _____

3. How many vision service locations or “outlets” does the plan include in the network? What is the percentage of vision locations available to Healthy Family Program members through the plan that are accepting new patients as of January 1, 2008?

Total number of vision service locations \_\_\_\_\_

Number accepting new patients \_\_\_\_\_

Percentage \_\_\_\_\_

4. Does the plan require all providers to have on-site dispensing capability? If not, what percentage of the provider network does not have the on-site dispensing capability?

5. Please complete the Vision Plan Providers Network Capacity Chart. This chart requires plans to list the percentage of providers accepting new patients and the estimated number of members that the providers can serve by county as of January 1, 2008

Vision Plan Providers Network Capacity Chart					
Vision Plan Name:					
COUNTY	Number of HFP Optometrists	Number of HFP Optometrists accepting new patients	Percentage of HFP Optometrists accepting new patients	Estimated number of HFP patients that can be served in each county	Number of current HFP members in the plan's service area (for each county served)
Alameda					
Alpine					
Amador					
Butte					
Calaveras					
Colusa					
Contra Costa					
Del Norte					
El Dorado					
Fresno					
Glenn					
Humboldt					
Imperial					
Inyo					
Kern					
Kings					
Lake					
Lassen					
Los Angeles					
Madera					
Marin					
Mariposa					
Mendocino					
Merced					
Modoc					
Mono					
Monterey					
Napa					
Nevada					
Orange					
Placer					
Plumas					
Riverside					
Sacramento					
San Benito					
San Bernardino					
San Diego					
San Francisco					
San Joaquin					
San Luis Obispo					
San Mateo					
Santa Barbara					
Santa Clara					
Santa Cruz					
Shasta					
Sierra					
Siskiyou					
Solano					
Sonoma					
Stanislaus					
Sutter					
Tehama					
Trinity					
Tulare					
Tuolumne					
Ventura					
Yolo					
Yuba					

6. Please respond to the following questions and describe the process used for delivering vision services.

<b>I. Members Access to Services</b>	
a)	Describe how the plan will assure that members who have had an initial eye examination continue to have annual vision exams.
b)	What accessibility guarantees are required in your plan's contracts with providers? For wait time for appointments, language capabilities, hours of operation?
c)	Please describe how plan providers notify the plan when they no longer accept new HFP patients.
<b>II. Member Cost Sharing</b>	
a)	Describe how the plan will determine its designation of the number and types of frames available at the \$5 copayment level.
b)	Describe how the plan will implement the federal government's requirement to exempt American Indian and Alaska Native children in HFP from all copayments in the program.
<b>III. Member Complaints and Grievances</b>	
a)	Describe the plan's policies and procedures for the submittal, processing and resolution of member complaints and grievances. Include in the description the Plan's mechanism for documenting, tracking and ensuring that member complaints and grievances are acknowledged within the required timeframes.
b)	How will the plan contact the member/applicant regarding complaints? (An example might be through the use of a designated staff working solely on complaints/grievances.) Please include how non-English speaking members will be assisted.
<b>IV. Member Services</b>	
a)	Describe how the plan will determine if there is sufficient bilingual staff on the telephone lines to serve the members in all the threshold languages.
b)	Describe the process that will be used to ensure compliance with the contractual requirement to provide an Identification Card, Provider Directory and Evidence of Coverage booklet to applicants, on behalf of members, no later than the member's effective date of coverage.
c)	Describe the process the plan uses to provide information to subscribers about how to access services (in addition to the information provided in the Evidence of Coverage or Certificate of Insurance). Please provide a copy of the document used to provide this information to subscribers. (See Exhibit A, Item II.F.1.)

7. Describe any agreements contemplated or in progress between the plan and other parties which may affect the plan's ownership, corporate structure or management during the January 2008 through June 2009 time period (as allowed by State and Federal Law).
8. Describe any restrictions or pending reviews by state (including the Medi-Cal program) or federal authorities for non-compliance with state or federal regulations or contracts for medical services.
9. Describe the process used by the plan to assure that any changes in contractual arrangements that will impact the plan's provider network are reported in a timely manner to the State

This 2008/2009 Vision Plan Fact Sheet for the Healthy Families program must be signed by the person authorized to sign the vision plan's contract.

To the best of my knowledge, all statements and data reported by \_\_\_\_\_  
(Vision Plan name) in this 2008/2009 Vision Plan Fact Sheet for the Healthy Families Program are true and accurate. I understand that all responses to questions included in the Fact Sheet except items # 7 and # 8 may be included in comparative charts in the Healthy Families Program brochure or other public documents produced by MRMIB.

Signed

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date



Enclosure 5  
Cultural and Linguistic Services Report

**CULTURAL AND LINGUISTIC SERVICES SURVEY**  
For Services in FY 2007-08

Plans should report in a multiple choice and narrative format (where indicated) the linguistically and culturally appropriate services provided and proposed to be provided to meet the needs of limited English proficient applicants and subscribers in the Healthy Families Program. Submission of this report fulfills the requirement in the 2005-08 contract for participating plans to submit a Cultural and Linguistic (C&L) report by December 10, 2007.<sup>1</sup>

**Submission Instructions**

- Plans must submit their completed C&L Surveys to the Managed Risk Medical Insurance Board (MRMIB) **by December 10, 2007**.
- Documents must be submitted electronically to [BQMmail@mrmib.ca.gov](mailto:BQMmail@mrmib.ca.gov) and should be compressed to 4 mgs or less and in a zipped file.

Note: Responses to all or part of the following questions may be made available to the public.

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<sup>1</sup> Reference: HFP Contract 2005-08, Exhibit A, Item III.C.3.c.).



Enclosure 5  
Cultural and Linguistic Services Report

Plan Name: \_\_\_\_\_

## I. Cultural and Linguistic Needs Assessment

- 1) How does the plan assess the Cultural and Linguistic needs of subscribers?  
Check all that apply.
- a. ☐ Group Needs Assessment (GNA) annual update
  - b. ☐ feedback from subscribers and subscriber representatives during plan meetings
  - c. ☐ subscriber feedback from phone, mail or web surveys
  - d. ☐ subscriber grievances and appeals
  - e. ☐ encounter and claims data
  - f. ☐ interpreter services utilization review
  - g. ☐ other (explain):

## II. Primary Care Physician Selection

- 2) When a subscriber has not selected a Primary Care Physician (PCP) what considerations does the plan take when using physician auto assignment?  
Check all that apply.
- a. ☐ subscriber language preference
  - b. ☐ language capabilities of provider office
  - c. ☐ provider proximity the subscriber's home
  - d. ☐ the plan does not require subscribers to select a PCP
  - e. ☐ other (explain):

## III. Identifying and Documenting Subscriber Language Preference

- 3) How does the plan identify the language preference of its subscribers?  
Check all that apply.
- a. ☐ from HFP subscriber enrollment data
  - b. ☐ during the welcome call
  - c. ☐ other (explain):
- 4) How does the plan make providers aware of subscribers' language preferences?  
Check all that apply.
- a. ☐ monthly subscriber eligibility reports with language preference
  - b. ☐ new enrollee notification with language preference
  - c. ☐ subscriber language preference is available to providers via the plan's secure web site
  - d. ☐ the plan does not make providers aware of subscriber language preference
  - e. ☐ other (explain):



Enclosure 5  
Cultural and Linguistic Services Report

- 5) Does the plan instruct providers in its network to record the language needs of subscribers?
- ☐ Yes, explain the process:
- ☐ No, explain:
- 6) Does the plan instruct providers to document in the medical record Requests/Refusals of language interpretive services?
- ☐ Yes, explain the process:
- ☐ No, explain:
- 7) How does the plan ensure providers comply with the items checked above?
- Check all that apply.
- a. ☐ train its providers on the need to document a request or refusal of interpreter services
- b. ☐ supply providers and their staff with Request/Refusal forms for interpreter services
- c. ☐ supply providers and their staff with chart labels identifying subscriber language needs
- d. ☐ implement an incentive program to reward provider offices that affirmatively attempt to identify language needs of LEP subscribers and record them on the medical charts (explain the program: \_\_\_\_\_)
- e. ☐ conduct reviews of providers' medical records during periodic audits and/or facility site reviews to check for documentation of the request for or refusal of interpreter services
- f. ☐ other (explain): \_\_\_\_\_

#### IV. Informing Subscribers of Interpretive Services

- 8) What methods does the plan utilize to inform its subscribers of the availability of no cost interpretive services?
- Check all that apply.
- a. ☐ welcome call/welcome letter
- b. ☐ evidence of coverage (EOC) or certificate of insurance (COI)
- c. ☐ other (explain): \_\_\_\_\_



Enclosure 5  
Cultural and Linguistic Services Report

**9) What information does the plan provide to subscribers regarding interpreter services?**

Check all that apply.

- a. ☐ availability of interpreter services to subscribers at no charge
- b. ☐ right not to use family subscribers, friends or minors as interpreters
- c. ☐ right to request an interpreter, during discussions of medical information such as diagnoses of medical conditions and proposed treatment options, and explanations of plans of care or other discussions with providers
- d. ☐ right to receive subscriber materials in the plan's threshold languages
- e. ☐ right to receive subscriber materials in alternative formats (Braille, large print, CD, DVD and oral translations)
- f. ☐ right to file a complaint or grievance if linguistic needs are not met
- g. ☐ other (please explain):

**V. Provision of Interpretive Services**

**10) How does the plan provide 24 hour interpreter services to HFP subscribers?**

Check all that apply.

- a. ☐ face-to-face interpreters
- b. ☐ telephone language line
- c. ☐ plan customer service (telephone/web system)
- d. ☐ other (explain):

**11) Does the plan provide "Interpreter Request Cards" or "I Speak Cards"?**

- ☐ Yes
- ☐ No

**12) Are community based organizations (CBOs) used by the plan and/or subcontractor to interpret for subscribers?**

- ☐ Yes (explain):
- ☐ No

**13) Explain the process used by providers and subscribers to notify the plan when interpreter services are needed.**

**14) When has the provision of face-to-face interpreters not been feasible at medical points of contact?**

**15) The plan agrees that the use of family members or friends as interpreters shall not be required or encouraged. Explain the steps used by the plan and providers to encourage the use of qualified interpreters.**



Enclosure 5  
Cultural and Linguistic Services Report

- 16) The plan also agrees that minors shall not be used as interpreters except for only the most extraordinary circumstances. Please describe any extraordinary circumstances when it was necessary to use minors as interpreters.

## VI. Staff Education and Training

- 17) Explain the process utilized by the plan to inform/train plan staff and provider staff on:
- i. the plan's language assistance program
  - ii. cultural competency
- 18) The plan shall provide initial and continuing training on cultural competency to staff and providers. Please list training sessions for the 2007-08 benefit year (include title, date, duration, and goals):
- 19) How does the plan obtain evaluation/feedback on cultural competency training?  
Check all that apply.
- a. ☐ post-training satisfaction surveys
  - b. ☐ discussion of training effectiveness at quality improvement meetings
  - c. ☐ other (please explain):

## VII. Monitoring Language Assistance Services

- 20) How does the plan monitor its language assistance program (interpretive services)?  
Check all that apply.
- a. ☐ feedback from subscribers and subscriber representatives during plan meetings
  - b. ☐ subscriber feedback from phone, mail or web surveys
  - c. ☐ findings from provider onsite audits conducted by the plan
  - d. ☐ review of subscriber grievances and appeals
  - e. ☐ review of encounter and claims data
  - f. ☐ interpreter services utilization review
  - g. ☐ other (explain):
- 21) How does the plan ensure subcontracted providers and/or vendors meet HFP cultural and linguistic services contractual requirements?  
Explanation:



Enclosure 5  
Cultural and Linguistic Services Report

### VIII. Points of Contact

**22)** At what non-medical and medical points of contact does the plan ensure language access for subscribers?

Check all that apply.

- a. ☐ during the appointment
- b. ☐ provider office reception
- c. ☐ appointment services phone or web site
- d. ☐ plan customer service
- e. ☐ subscriber orientation sessions
- f. ☐ health education classes
- g. ☐ other (please explain):

**23)** What methods are used by the plan to ensure language access at the points of contact checked above?

Check all that apply.

- a. ☐ hire staff with conversational fluency in multiple languages
- b. ☐ hire staff with bilingual fluency in medical terminology
- c. ☐ train staff to collect medical history data and respond to subscribers with culturally appropriate oral translations and forms
- d. ☐ provide interpreters with access to medical dictionaries/glossaries to use for accuracy in translation (i.e.; books; website; computer software)
- e. ☐ give plan/provider staff consistent interpreter training by experienced and properly trained interpreters
- f. ☐ periodically assess the language proficiency of the plan's identified medical and non-medical staff that have subscriber contact
- g. ☐ conduct audits of provider sites to confirm ongoing language capabilities of providers and staff
- h. ☐ other (explain):

### IX. Provider Language Capabilities

**24)** Which tools does the plan use to report the on-site linguistic capabilities of providers and provider office staff to subscribers?

Check all that apply.

- a. ☐ written "hard" records
- b. ☐ electronic database
- c. ☐ provider directory
- d. ☐ website
- e. ☐ other (please explain):

**25)** How does the plan verify the proficiency of providers who indicate they are bilingual?  
Explanation:



Enclosure 5  
Cultural and Linguistic Services Report

## X. Non-English Language Translations and Readability of Subscriber Materials

**26)** For each of the subscriber materials listed below, please list the non-English languages in which the plan translates the materials. Please note that the information provided will be included in comparative charts in the Healthy Families Program brochure or other public documents (Reference: HFP Contract, Exhibit A, Item III.C.2.a).

DOCUMENT	LANGUAGE/s
Evidence of Coverage or Certificate of Insurance	
Subscriber Handbook and information on how to use the subscriber handbook	
Welcome Letter	
Newsletters	
Preventive services reminders	
Health Education Material	
Letter and notices reducing, denying or terminating services or benefits ( <i>Notice of Action</i> )	
Forms	
Patient satisfaction survey (ex: CAHPS)	
Notice of free language assistance	
Provider listings (directory)	
Marketing materials	
Complaints and grievance materials	
Any documents required by law or affecting any legal right or responsibility (ex: Disclosure and Consent Forms, etc.)	
Other (please describe):	

**27)** How does the plan ensure a sixth grade readability level for subscriber documents (including translated documents)?  
Explanation:

## XI. Translation Process

**28)** What is the plan's process for translation of documents?  
Explanation:



Enclosure 5  
Cultural and Linguistic Services Report

**29)** The plan agrees that the translation process shall include the use of qualified translators for translating and editing, proofreading and professional review. Which of the following activities does the plan undertake to ensure the quality of translated materials?

Check all that apply.

- a. ☐ contract and use of certified translation companies that follow a step-by-step translation process
- b. ☐ perform back translation of material into its source language for comparison and accuracy by certified translation vendors other than the original translator
- c. ☐ have an internal review committee that includes a medical and/or legal “professional reviewer” who reviews translated materials for cultural appropriateness
- d. ☐ proof-read and edit of documents by a separate qualified translation editor/proof reader
- e. ☐ use of computer technology as part of the process for producing culturally and linguistically appropriate translation
- f. ☐ other (please explain):

**30)** Which of the following activities does the plan use to ensure that subscribers who are unable to read the written materials that have been translated into non-English languages have an alternate form of access to the contents of the written materials?

Check all that apply.

- a. ☐ encourage subscribers to call the plan if they need help in understanding any of the plan’s written materials
- b. ☐ provide an oral translation of the material in a subscriber’s preferred language or arrange for this to be done by a competent interpreter service
- c. ☐ make the content of written materials available in alternative formats such as Braille, CD, and audio cassette
- d. ☐ other (please explain):

## **XII. Plan Internal Systems and Quality Improvement**

**31)** Which of the following activities does the plan undertake in developing its internal systems to meet the cultural and linguistic needs of the subscribers?

Check all that apply.

- a. ☐ incorporate cultural competency in the plan's mission
- b. ☐ establish and maintain a process to evaluate and determine the need for special initiatives related to cultural competency
- c. ☐ develop recruitment and retention initiatives to establish organization-wide staffing that is reflective and/or responsive to the needs of the community
- d. ☐ assess the cultural competence of plan providers on a regular basis
- e. ☐ establish a special office or designated staff to coordinate and facilitate the integration of cultural competency guidelines
- f. ☐ distribute communication tools to staff relating to cultural competency issues (e.g., those tools generally used to distribute other operational policy-related issues)
- g. ☐ participate with government, community, and educational institutions in matters related to best practices in cultural competency in managed health care to ensure an outside perspective is maintained in plan policies
- h. ☐ maintain an information system capable of identifying and profiling cultural and linguistic specific patient data
- i. ☐ evaluate the effectiveness of strategies and programs in improving the health status of cultural-defined populations
- j. ☐ evaluate satisfaction feedback from subscriber surveys, staff, and/or providers
- k. ☐ evaluate encounter/claims data to improve services/processes
- l. ☐ evaluate input from subscriber advisory committees
- m. ☐ other

**32)** Explain any of the activities checked above.

**33)** As part of the plan's quality improvement efforts, does the plan utilize the following data to evaluate cultural and linguistic services and outcomes of cultural and linguistic activities?

Check all that apply.

- a. ☐ subscriber complaints and grievances
- b. ☐ results from subscriber satisfaction surveys
- c. ☐ utilization and other clinical data that may reveal health disparities as a result of cultural and linguistic barriers
- d. ☐ other (please explain):

**34)** For the items checked above, does the plan utilize primary language, race and ethnicity data to assess quality of care and monitor health disparities?

Explanation:



Enclosure 5  
Cultural and Linguistic Services Report

**35)** Has the plan implemented specific strategies or programs to address identified health disparities?

Explanation:

**36)** Attach the following cultural and linguistic related information

- a. A list of interpreter agencies used (including CBOs).
- b. Policies and Procedures for the plan's language assistance program.
- c. A list of the plan's threshold languages.

Highlight of Innovative Processes or Services:

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Additional Comments:

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**PREPARER'S INFORMATION**

Name and Title:

Mailing Address:

E-mail:

Phone #:

## ENCLOSURE 6 Instructions

### California Healthy Families Vision Rate Development for Contract Year July 2008 through June 2009

#### Instructions

**Prepare a separate projection for each Healthy Families Product. Highlighted cells containing certain key calculations are locked and cannot be modified.**

**Schedule 1:** If applicable, provide historical utilization and costs for your Healthy Families Program (HFP) population by region, and for the state as a whole if your product is in more than one region. Provisions for incurred but not reported (IBNR) claims should be included in the reported figures, as appropriate. For each category of service, please provide the following:

- 1) Please provide the Healthy Families member months for the data period. This information is used in the calculated fields to derive the "Annual Utilization rate per 1,000 members" **[Column D]** and the "Gross Cost Per Unit of Service" **[Column E]**.
- 2) **Column A:** A description of what the unit counts represent (for example, visits, claims, units of service).
- 3) **Column B:** The Total Cost by vision service.
- 4) **Column C:** The Total Unit Count by vision service.
- 5) **Column D - Calculated Field:** The annual utilization rate per 1,000 members. This is calculated as units of service provided during the data period divided by the member months for the data period multiplied by 12,000.
- 6) **Column E - Calculated Field:** The Gross Cost per Unit of Service. This is calculated as total costs of service **[Column B]** divided by the total units of service **[Column C]** provided during the data period.
- 7) **Column F:** The Average Copay per Unit of Service. This should be calculated as the total copayments collected divided by the total units of service, within each category of service.
- 8) **Column G - Calculated Field:** The Net Cost Per Unit of Service. This is calculated as the "Gross Cost per Unit" **[Column E]** minus the "Copay per Unit" **[Column F]**.
- 9) **Column H - Calculated Field:** The Cost per Member per Month (PMPM). This is calculated by multiplying the "Annual Utilization Rate per 1,000 members" **[Column D]** and the "Net Cost per Unit" **[Column G]** and dividing the results by 12,000.
- 10) **Column I:** The percentage of enrollees receiving service during the year.

## ENCLOSURE 6 Instructions

### California Healthy Families Vision Rate Development for Contract Year July 2008 through June 2009

#### Instructions

**Schedule 2:** Using experience from the HFP provide projected trends and other adjustments for your HFP population by region. For 2007-2008, plans new to the HFP within the past 2 years should skip to Schedule 3B.

1) Enter your expected annual utilization and unit cost trend rates from the data period through the 2008-2009 contract period. For example, if you project Restorative utilization will decrease by 5% per year and unit costs will increase by 10% per year, enter -5 and 10 in the Utilization and Unit Cost columns, respectively. The annual trend rate for per member per month costs is automatically calculated. The trend factors (the amount by which your reported experience will be adjusted for trend are also automatically calculated. If the appropriate number of trend months is different than 24, please enter the correct number and provide an explanation for the difference. The number of trend months should be from the midpoint of the experience period to the midpoint of the contract period (1/1/2009). Also, please provide an explanation of the source of your trend assumptions in the space provided.

2) As appropriate, enter any additional adjustment factors to be applied to project historical costs to the contract period. These factors will be automatically applied to the historical utilization rates to produce the projected utilization in Schedule 3A. Provide a brief description of the reason for the adjustments next to the factor. Further space is provided at the bottom of the schedule if necessary to adequately describe the nature of the adjustments.

**Schedule 3A:** This schedule develops the expected 2008-2009 vision care costs for the HFP population in each region. If Healthy Families experience was reported in Schedule 1, Schedule 3A is automatically populated using the reported experience and the assumptions in Schedule 2. If experience other than Healthy Families is being used, perform the cost projections using Schedule 3B.

**Schedule 3B:** Complete this schedule only if your plan was new to HFP within the past two years. You may use data other than HFP experience for the rate development process. Identify the data source for the utilization and cost assumptions. As in Schedule 1, enter the utilization, unit cost, and copayment assumptions in columns (A), (B), (C), (F). Columns (D), (E), (G), (H) are calculated fields. The unadjusted vision care cost will be automatically calculated.

**Schedule 4:** Report administrative costs per member per month for the HFP in the categories shown. Enter your projected vision care costs from Schedule 3A or Schedule 3B, as appropriate. Schedule 4 calculates your rate bid as the sum of the administrative costs and the projected vision care costs.

## ENCLOSURE 6 Instructions

### California Healthy Families Vision Rate Development for Contract Year July 2008 through June 2009

#### Instructions

**Schedules 5 and 6:** Complete the loss ratio report. Include all incentives payments made or anticipated. For current HFP plans, the expenses reported on Line 11 (TOTAL VISION) of Schedule 6 should be equivalent to the Total Vision Care Expenditures calculated at the bottom of Schedule 1. should be a consolidation for all regions. Also, this Schedule 5 and 6 should be in the workbook for the first region that your plan is submitting a bid for (ie. If your plan is submitting a bid for Regions 1 through 6, then the consolidated Schedule 5 and 6, will be in the workbook for Region 1).

**Schedule 6A:** Complete the loss ratio report for the current year, through November and include IBNR for this period on line 10.

**Schedule 7:** Fill out this schedule if your loss ratio is below your contractual level. The schedule asks for an explanation if the loss ratio is below the contractual level and for a description of the methods you intend to use to reach your target loss ratio.

**Schedule 8a:** This is a presentation of your rate projection and must equal the prices on Schedule 4.

**Schedule 8b:** This is a presentation of your rate projection and must equal the prices on Schedule 4 less the cost of polycarbonate frames and lenses presented on either schedule 3a or 3b.

**Schedule 9:** List number of members by payor (Medical vs Other).

**Schedule 10:** Provide a certification by your vision plan's actuary that the experience for 2004-2005 is accurate and that the assumptions used to project costs during the contract period are reasonable.

**Submit Schedules 1 through 10 via e-mail to [HFPRates08-09@mrrib.ca.gov](mailto:HFPRates08-09@mrrib.ca.gov) by 01/04/08. Mail a signed hard copy of Schedule 10 (Actuarial Certification) to Ms. Jackie Baker c/o MRMIB, 1000 G St. Suite 450, Sacramento, CA 95814. All documents must be received by 5 p.m., January 11, 2008.**

# Schedule 1

**California Healthy Families**  
**July 2008 - June 2009 Rate Development**  
**Utilization and Cost Experience July 2006 through June 2007**  
 Fill out one for each Region and Statewide (if applicable)

Plan Name \_\_\_\_\_

(Specify Region or Statewide) \_\_\_\_\_

HFP Member Months July 2006 - June 2007

**Vision Services**

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)
	Description of Units (e.g., days, claims, units of service)	Total Cost	Total Units	Annual Units per 1000 Members	Gross Cost per Unit	Copay per Unit	Net Cost per Unit	Cost PMPM	Percent of enrollees receiving service during the year
Exams					\$ -		\$ -	\$ -	
Frame & Lenses (Regular)					\$ -		\$ -	\$ -	
Frame & Lenses (Polycarbonate)					\$ -		\$ -	\$ -	
Contact Lenses					\$ -		\$ -	\$ -	
Other Services					\$ -		\$ -	\$ -	
Capitation									
Provider Incentive Payments									
Net Reinsurance Costs									
UM/QA Costs									
Total including Provider Incentive Payments								\$ -	
Total excluding Provider Incentive Payments								\$ -	
Total Vision Care Expenditures								\$ -	

# Schedule 2

## California Healthy Families

### July 2008 - June 2009 Rate Development

#### Assumptions Used to Project Costs for July 2008 - June 2009

Fill out one for each Region

Plan Name \_\_\_\_\_

Specify Region \_\_\_\_\_

Months of Trend (should be 24 if data from 2006/2007 contract year used as the base):

If different than 24, please explain: \_\_\_\_\_

#### Vision Services

Annualized Trend Rates			Trend Factors			Other Adjustments	
Utilization	Unit Cost	PMPM	Utilization	Unit Cost	PMPM	Factors	Description
		0.00%	1.000	1.000	1.000	1.000	
Exams							
Frame & Lenses (Regular)		0.00%	1.000	1.000	1.000	1.000	
Frame & Lenses (Polycarbonate)		0.00%	1.000	1.000	1.000	1.000	
Contact Lenses		0.00%	1.000	1.000	1.000	1.000	
Other Services		0.00%	1.000	1.000	1.000	1.000	
Capitation					1.000	1.000	
Provider Incentive Payments					1.000	1.000	
Net Reinsurance Costs					1.000	1.000	
UM/QA Costs					1.000	1.000	
Total					1.000	1.000	

Source of trend assumptions:

\_\_\_\_\_

Other Adjustments:

\_\_\_\_\_

# Schedule 3A

**California Healthy Families**  
**July 2008 - June 2009 Rate Development**  
**Projected Vision Care Costs for July 2008 - June 2009**  
**Based on Healthy Families Experience Projection**  
 Fill out one for each Region

Plan Name \_\_\_\_\_

Specify Region \_\_\_\_\_

	(A)	(B)	(C)	(D)	(E)
Vision Services	Annual Units per 1000 Members	Gross Cost per Unit	Copay per Unit	Net Cost per Unit	Cost PMPM
Exams		\$ -	\$ -	\$ -	\$ -
Frame & Lenses (Regular)		\$ -	\$ -	\$ -	\$ -
Frame & Lenses (Polycarbonate)		\$ -	\$ -	\$ -	\$ -
Contact Lenses		\$ -	\$ -	\$ -	\$ -
Other Services		\$ -	\$ -	\$ -	\$ -
Capitation					\$ -
Provider Incentive Payments					\$ -
Net Reinsurance Costs					\$ -
UM/QA Costs					\$ -
Total including Provider Incentive Payments					\$ -
Total excluding Provider Incentive Payments					\$ -

# Schedule 3B

**Projected costs for July 2008 - 2009**  
**July 2008 - June 2009 Rate Development**  
**Projected Vision Care Costs for July 2008 - June 2009**  
**New Plans (in Healthy Families Program 2 years or less)**  
 Fill out one for each Region

Plan Name \_\_\_\_\_

Specify Region \_\_\_\_\_

Data source for developing assumptions [e.g., Commercial, Other (describe)]: \_\_\_\_\_

HFP Member Months July 2006 - June 2007

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
	Description of Units (e.g., days, claims, units of service)	Total Costs	Total Units	Annual Units per 1000 Members	Gross Cost per Unit	Copay per Unit	Net Cost per Unit	Cost PMPM
Vision Services								
Exams					\$ -		\$ -	\$ -
Frame & Lenses (Regular)					\$ -		\$ -	\$ -
Frame & Lenses (Polycarbonate)					\$ -		\$ -	\$ -
Contact Lenses					\$ -		\$ -	\$ -
Other Services					\$ -		\$ -	\$ -
Capitation								
Provider Incentive Payments								
Net Reinsurance Costs								
UM/QA Costs								
Total							\$ -	
Adjustment for California Children's Services								
Total after adjustments							\$ -	
Total vision expenditures costs after adjustments								\$0

# Schedule 4

**California Healthy Families**  
**July 2008 - June 2009 Rate Development**  
**Projected costs for July 2008 - June 2009**  
**Administrative Costs and Rate Bid**  
 Fill out one for each Region

Plan Name \_\_\_\_\_

Specify Region \_\_\_\_\_

**Administrative costs**

Claims processing, data processing, customer service  
 General administrative overhead  
 Marketing: Communication, education, printing  
 Provider contracting, managed care network maintenance  
 Risk charges (identify) \_\_\_\_\_  
 Profit  
 Other (identify) \_\_\_\_\_

Total administrative costs

Total vision care costs from Schedule 3A or 3B

Rate projection ( total per member per month premium)

Cost PMPM	Percent of premium
	0.00%
	0.00%
	0.00%
	0.00%
	0.00%
	0.00%
	0.00%
\$ -	0.00%
\$ -	0.00%
\$ -	0.00%

**HEALTHY FAMILIES PROGRAM**  
**July 2008 - June 2009 Rate Development**  
**7/06 - 6/07 LOSS RATIO REPORT**

Plan Name \_\_\_\_\_

Did your plan have a minimum 1,000 HFP enrolled subscribers per month for six or more months in the July 06 - June 07 benefit year?

Yes  
No


**NOTE: All Plans, regardless of enrollment must complete the loss ratio report.**

Total \$ amount of covered benefits for services provided to HFP subscribers from 7/1/06 - 6/30/07 \*

\$ -
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Total \$ amount of premiums received from the state for HFP subscribers from 7/1/06 - 6/30/07 \*\*

\$ -
------

Total \$ amount made in incentive payments from 7/1/06-6/30/07 \*\*\*

\$ -
------

Healthy Families Program 7/1/06 - 6/30/07 Benefit Year Actual Loss Ratio including Incentive Payments  
**(Sch. 6: (Item 11 PLUS Item 4) DIVIDED by Item 1 = (Item 11+ Item 4) / Item 1)**

--

Healthy Families Program 7/1/06 - 6/30/07 Benefit Year Actual Loss Ratio excluding Incentive Payments  
**(Sch. 6: Item 11 DIVIDED by Item 1 = Item 11 / Item 1)**

--

Healthy Families Program 7/1/06 - 6/30/07 Benefit Year Minimum Loss Ratio in Contract

--

Difference between Actual Loss Ratio including Incentive Payments above  
and Minimum Loss Ratio in Contract (Over / (Under))

--

Difference between Actual Loss Ratio excluding Incentive Payments above  
and Minimum Loss Ratio in Contract (Over / (Under))

--

Interim Loss Ratio from Schedule 6A

--

\* Total from Item # 11 on the Statement of Revenue and Expenses Report, Schedule 6

\*\* Total from Item # 1 on the Statement of Revenue and Expenses Report, Schedule 6

\*\*\* Total from Item # 4 on the Statement of Revenue and Expenses Report Schedule 6

If your plan's **Actual Loss Ratio** is lower than the **Minimum Loss Ratio in Contract**, complete the Loss Ratio Description Schedule 7

If your plan's **interim loss ratio** data suggests the current year's **actual loss ratio** may not achieve 79%, please comment Schedule 7 at question #8.

# Schedule 6

## HEALTHY FAMILIES PROGRAM 2006-2007 LOSS RATIO REPORT STATEMENT OF REVENUE AND EXPENSES

Plan Name \_\_\_\_\_ Healthy Families Benefit Year  
July 1, 2006 - June 30, 2007

SUBSCRIBER MONTHS (Healthy Families Program subscribers only) \_\_\_\_\_

### REVENUES: (Healthy Families Program only)

1. Premium Payments from State	
--------------------------------	--

### AFFILIATED ENTRIES AND NONAFFILIATED ENTRIES:

2. Incentive Payments to affiliated parties	
3. Incentive Payments by to nonaffiliated parties	
4. Total Incentive Payments	\$ -

### EXPENSES: (Healthy Families Program only)

#### Vision Services:

5. Exams	
6. Frames & Lenses	
7. Contact Lenses	
8. Other Services	
9. Reinsurance Expenses	
10. Incentive Pool Adjustment	
11. TOTAL VISION SERVICES (Line 5 to Line 10)	\$ -

#### Administration:

12. Compensation	
13. Interest Expense	
14. Occupancy, Depreciation and Amortization	
15. Management Fees	
16. Marketing	
17. Affiliate Administration Services	
18. Aggregate Write-ins for Other Administration Expenses	
19. TOTAL ADMINISTRATION (Line 12 to Line 18)	\$ -
20. TOTAL EXPENSES (Line 4, Line 11, & Line 19)	\$ -
21. INCOME (LOSS) (Line 1 less Line 20)	\$ -
22. Extraordinary Item	
23. Provision for Taxes	
24. NET INCOME (LOSS) (Line 21 plus Line 22 & Line 23)	\$ -

Line 11 TOTAL VISION EXPENSE	\$ -
Schedule 1 Total Vision Care Expenditures	\$ -
Difference	\$ -

Explain any difference: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Schedule 6A

## HEALTHY FAMILIES PROGRAM July 2008 - June 2009 Rate Development Interim Statement of Revenue & Expenses

**PLAN NAME** \_\_\_\_\_

Total Capitation Payments Received July 2007 through November 2007

PLAN CAPITATION RECEIVED

**AFFILIATED ENTRIES AND NONAFFILIATED ENTRIES:**

1. Incentive Payments to affiliated parties	
2. Incentive Payments by to nonaffiliated parties.	
3. Total Incentive Payments	

**EXPENSES: (Healthy Families Program only)**

**Vision Services:**

5. Exams	
6. Frames & Lenses	
7. Contact Lenses	
8. Other Services	
9. Reinsurance Expenses	
10. Estimated IBNR	
11. Incentive Pool Adjustment	
12. TOTAL VISION SERVICES ( <i>Line 5</i> to <i>Line 10</i> )	

**INTERIM LOSS RATIO**

<b>0.00%</b>
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## HEALTHY FAMILIES PROGRAM 2006-2007 LOSS RATIO REPORT

Plan Name \_\_\_\_\_

If your plan's Actual Loss Ratio is lower than your Minimum Loss Ratio in Contract, provide a detailed response explaining 1) why the actual loss ratio was significantly below the contractual standard and 2) plans you have to assure the Board that future loss ratios will be consistent with the contractual standard agreed to in your contract. Please respond to the following specific questions. Your response can be provided in a separate file if you prefer.

1. Why is your company's actual loss ratio substantially lower than the projected value for the 2006-2007 benefit year?

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2. How do your HFP provider payments compare to your contractual payments in:

- The MediCal Program?
- Commercial products?
- The payment schedules set forth in the Medicare program?

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3. How does your company's HFP utilization experience in each of the service categories compare to your company's children's utilization experience in:

- The MediCal Program?
- Commercial products?

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4. Does your plan offer providers any type of "end of year" payment incentive program? If so, please describe. Include in your description any differences in the allocation of incentive payments to affiliated and non-affiliated groups or other distinctions in how incentive payments are made by group.

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5. What does your plan do to encourage families to seek out and utilize preventive services? Do you have plans to improve provider's behavior with regard to providing and reporting appropriate preventive care visits? If so, please describe.

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6. Are there other factors that explain your plan's low loss ratio? If yes, please describe.

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7. What are the methods you will use to reach your target loss ratio?  
When would you expect that to occur?

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8. [For current year interim loss ratio data only] Please comment as appropriate.

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## Schedule 7

## Schedule 8a

Healthy Families Program  
Contract No. \_\_\_\_\_

Confidential Attachment

Rates of Payment  
Page \_\_\_\_ of \_\_\_\_

### ***PREMIUM RATES WITH FRAMES AND POLY CARBONATE LENSES***

Premium Rates for the July 1, 2008 - June 30, 2009 benefit year.

Note: Bid should match the figure shown in Schedule 4.

	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per Subscriber age 1 to 18 years of age						

## Schedule 8b

Healthy Families Program  
Contract No. \_\_\_\_\_

Confidential Attachment  
Rates of Payment  
Page \_\_\_\_ of \_\_\_\_

### ***PREMIUM RATES WITH FRAMES AND WITHOUT POLYCARBONATE LENSES***

Premium Rates for the July 1, 2008 - June 30, 2009 benefit year.

Note: Bid should match the figure shown in Schedule 4 less line Schedule 3A line 16, Column E c

	Geographic Area 1	Geographic Area 2	Geographic Area 3	Geographic Area 4	Geographic Area 5	Geographic Area 6
Per Subscriber age 1 to 18 years of age						

## Schedule 9

**HEALTHY FAMILIES PROGRAM**  
**July 2008 - June 2009 Rate Development**  
**Number of Members for Dec 31, 2006 and Dec 31, 2007**

Plan Name: \_\_\_\_\_  
Contract No.: \_\_\_\_\_  
Contact Person & Phone Number for Follow-Up: \_\_\_\_\_

Payor	As of 12/31/2006		As of 12/31/2007	
	Subscribers	Subscribers and Dependents	Subscribers	Subscribers and Dependents
Medi-Cal				
All California Business				

**California Healthy Families  
July 2008 - June 2009 Rate Development  
Projected costs for July 2008 - June 2009 and Loss Ratio Report  
Certification of Claims Experience and Cost Projections**

Plan Name \_\_\_\_\_

I certify that the claims experience and cost projections are accurate and appropriate for the California Healthy Families Program.

By: \_\_\_\_\_  
Print name Date  
  
\_\_\_\_\_  
Signature & Title Phone number